ADULT ORTHODONTIC ACQUAINTANCE CARD

Patient #_____ Date_____

Patient's name_____Age_____Birthdate_____Sex_____

Last First Middle Nickname

Address_____Telephone (____)_____

Street City State Zip Cell (____)_____

Whom may we thank for referring you to our office? (1)_____(2)_____

Patient's dentist_____ Last Visit_____Physician_____

Patient's interests and hobbies_____ Purpose of this appointment_____

PERSONAL HISTORY E-mail_____

Person financially responsible for this treatment_____SSN_____DOB_____

Address_____City & State_____Zip_____How long?_____

Patient employed by_____How long?_____Occupation_____

Business address_____Telephone_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐

Do you have insurance that may cover part of our professional services? Yes ☐ No ☐ Company_____

I understand that where appropriate, credit bureau reports may be obtained. Yes ☐ No ☐

Name of spouse_____SSN_____DOB_____

Spouse employed by_____How long? _____Occupation _____

Business address_____Telephone_____Cell_____

MEDICAL HISTORY ***Please check any of the following conditions or problems that you have experienced:***

☐ Anemia	☐ Diabetes	☐ Excessive Bleeding	☐ Kidney
☐ Arthritis	☐ Emotional Disorder	☐ Eyes	☐ Liver (Hepatitis)
☐ Asthma	☐ Endocrine (Hormone)	☐ Hearing	☐ Rheumatic Fever
☐ Bone (fracture)	☐ Epilepsy or Fainting	☐ Heart	☐ Other

Have you ever been informed by a physician that you carry or have been exposed to a virus (i.e. Hepatitis, AIDS, Herpes, or other immuno-suppressive disorder)? Yes ☐ No ☐_____

Are you in good health? Yes☐ No ☐ Women – Are you pregnant? Yes☐ No☐

List any drugs or medications now being taken:_____Give reasons:_____

List any allergies or drug sensitivities (i.e. aspirin, penicillin, novicaine, etc.)_____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth?_____ Yes ☐ No☐

Do you have any speech problems?_____ Yes ☐ No☐

Are you a mouth breather? While awake?_____While asleep?_____ Yes ☐ No☐

Have you ever been informed or any missing or extra permanent teeth?_____ Yes ☐ No☐

Has an orthodontist been consulted previously? Whom?_____Where?_____When?_____ Yes ☐ No☐

Has any family member had orthodontic treatment?_____Where?_____When?_____ Yes ☐ No☐

Do you ever have any clicking/popping or pain upon opening or closing the mouth (TMJ disorder)?_____ Yes ☐ No☐

Do you clench or grind teeth?_____ Yes ☐ No☐

Has your jaw ever "locked" open or closed? _____When?_____ Yes ☐ No☐

Do you have headaches or tenderness of your jaw muscles?_____ Yes ☐ No☐

Remarks, if any: _____

I authorize this office to obtain from or disclose information to my insurance company, family dentist, other specialist, and/or my medical doctor.

Signature of Patient:_____