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Specialist in Orthodontics—Adults and Children

Adult Acquaintance Sheet

Date: _____

Name: _____ Sex: ___ Date of Birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
E-mail Address: _____
Dentist: _____ Telephone: _____
Address: _____
Physician: _____ Telephone: _____
Address _____
Occupation: _____ Bus. Telephone: _____
Employer's Name and Address: _____
_____
Dental Insurance Name: _____
Soc. Sec. #: _____ Marital Status: _____ Number of Children _____
Spouse's Name: _____ Soc. Sec. #: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Bus. Telephone: _____
Employer's Name and Address: _____
_____
Dental Insurance Name: _____

Dental History

Date of last dental check-up: _____
Injury or Trauma to face or teeth: _____
Habits (e.g.: smoking, lip biting, nail biting, thumb sucking etc.): _____
_____
Breathing: ☐ Nose ☐ Mouth Difficulty at night (yes or no): _____
Bruxism (grinding teeth): ☐ Yes ☐ No ☐ At night ☐ Daytime
Jaw joint problems (TMJ): ☐ Noise ☐ Pain
☐ Soreness & Stiffness ☐ Earaches/Ringing
Reason you are seeking orthodontic treatment: _____
_____
Have you had any experience with or seen another orthodontist?
☐ Yes ☐ No If yes, Name? _____

Medical History

General health: ☐ excellent ☐ fair ☐ poor
Presently under care for: _____
Birth Defects: _____
Drugs & Medications being taken now (drug and dose):
Allergic to what medications: _____
_____

Please circle any of the following which you have had or may have at the present time

Adenoids Removed	Drug Addiction	Kidney Disorder
Allergies	Endocrine Disorder	Liver Disorder
AIDS (HIV Positive)	Epilepsy	Lung Disorder
Anemia	Epistaxis (nosebleeds)	Mitral Valve Prolapse
Angina Pectoris	Fainting Spells	Neurosis
Arthritis	Genital Herpes	Pain in Jaw Joint
Artificial Heart Valve	Glaucoma	Psychiatric Treatment
Artificial Joint	Hay Fever	Rheumatic Fever
Asthma	Heart Disease or Attack	Rheumatism
Blood Disorder	Heart Failure	Scoliosis
Blood Transfusion	Heart Murmur	Seizures
Bone Disorder	Heart Pacemaker	Sinus Trouble
Breathing Difficulties	Heart Surgery	Tonsils Removed
Cold Sores	Hepatitis	Tuberculosis (TB)
Congenital Heart Disease	High Blood Pressure	Thyroid Disease
Convulsions	Hospitalized	Venereal Disease
Damaged Heart Valve	Hyperactivity	X-Ray treatmento (not diagnostic)
Diabetes	Injuries	**None of the Above**
Dizzines	Jaundice	

Do you have any medical conditions not listed above that you feel we should know about (Explain)? _____
_____
Please give greater details where necessary: _____
_____
_____
_____
Female Patients: Is there any chance that you are pregnant? ☐ Yes ☐ No

Questionnaire completed by _____ Relation to patient _____
Whom may we thank for referring you to our office for orthodontics? _____
_____
Any additional comments? _____
_____
_____
_____
_____