Jeffrey D. Felicetti, D.D.S., C.A.G.S.

Specialist in Orthodontics - Adults and Children

Acquaintance Sheet

Date:_____

Name:_____ Nickname:_____ Sex:_____
Date of Birth:_____ Age: Years_____ Months_____
Address:_____
City:_____ State:_____ Zip:_____
Telephone: Home_____ Cell_____ Soc. Sec. #:_____
Primary Email Address:_____
Dentist:_____ Telephone:_____ Address:_____
Physician:_____ Telephone:_____ Address:_____
Occupation:_____ Bus. Telephone:_____
Employer's Name and Address:_____
Dental Insurance Name / ID #:_____

Marital Status: Single_____ Married_____
Spouse's Name:_____ Soc. Sec. #:_____ DOB:_____
Address:_____ City:_____ State:_____ Zip:_____
Occupation:_____ Bus. Telephone:_____
Employer's Name and Address:_____
Dental Insurance Name / ID #:_____
Number of Children:_____

Dental History

Date of last dental check-up:_____
Injury or Trauma to face or teeth:_____
Thumb sucking: Yes_____ No_____ Discontinued at what age:_____
Habits (e.g.: lip biting, nail biting, etc.):_____
Breathing: Nose_____ Mouth_____ Difficulty at night_____
Bruxism (grinding teeth): Yes_____ No_____ At night_____ Daytime_____
Jaw joint problems (TMJ): Noise_____ Pain _____ Soreness / Stiffness_____ Earaches / Ringing_____
Patient interest in treatment: _____ Patient wants treatment
_____ Unwilling but agrees if treatment is necessary
_____ Apprehensive

Reason you are seeking orthodontic treatment?_____
_____

I'm interested in: Traditional Braces_____ Clear Aligners (Invisalign/Clear Correct) _____

Have you had any experience with or seen another orthodontist? Yes_____ No_____
If yes, Name?_____

****** OVER ******

Medical History

General health: excellent_____ fair_____ poor_____
Presently under care for:_____
Birth defects:_____
Drugs & Medications being taken now (drug/used for/dose):_____
_____
Allergic to what medications:_____

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

Adenoids Removed
Allergies
AIDS (HIV Positive)
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disorder
Blood Transfusion
Bone Disorder
Breathing Difficulties
Cold Sores
Congenital Heart Disease
Convulsions
Damaged Heart Valve
Diabetes
Dizziness
Drug Addiction
Endocrine Disorder
Epilepsy
Epistaxis (Nosebleeds)
Fainting Spells
Genital Herpes
Glaucoma
Hay Fever
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hepatitis
High Blood Pressure
Hospitalized
Hyperactivity (ADHD)
Injuries
Jaundice
Kidney Disorder
Liver Disorder
Lung Disorder
Mitral Valve Prolapse
Neurosis
Pain in Jaw Joint
Psychiatric Treatment
Rheumatic Fever
Rheumatism
Scoliosis
Seizures
Sinus Trouble
Tonsils Removed
Tuberculosis (TB)
Thyroid Disease
Venereal Disease (STD)
X-ray Treatment (not diagnostic)

None of the Above

Do you have any medical conditions not listed above that you feel we should know about? (Explain)
_____
Please give greater details where necessary:_____
_____

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