Orthodontic Acquaintance • PERSONAL INFORMATION

Date Today: _____

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Name of Family Physician: _____

Whom can we thank for referring you to this office? _____

If transfer: _____
PREVIOUS ORTHODONTIST ADDRESS PHONE

Information for ADULT Patients:

Place of Business: _____ Business Phone: _____

Occupation: _____ Social Security #: _____ Marital Status: _____

Name of Spouse: _____ Occupation: _____

MEDICAL HISTORY

Are you in good health?	❒ Yes	❒ No	Reason: _____
Any major or unusual illnesses?	❒ Yes	❒ No	Explain: _____
Currently under physician's care?	❒ Yes	❒ No	Reason: _____
Currently taking medication?	❒ Yes	❒ No	List: _____
Allergies?	❒ Yes	❒ No	List: _____
Drug sensitivity?	❒ Yes	❒ No	List: _____
Women: Are you pregnant?	❒ Yes	❒ No	
Are you a smoker?	❒ Yes	❒ No	

Please check if you have had any of the following:

- ❒ Anemia
- ❒ Blood Disease
- ❒ Prolonged Bleeding
- ❒ Hepatitis
- ❒ AIDS antibody positive
- ❒ Jaundice
- ❒ Rheumatic Fever
- ❒ Heart Disease
- ❒ Tuberculosis
- ❒ Diabetes
- ❒ Endocrine Problems
- ❒ Bone Disorders
- ❒ Epilepsy
- ❒ Herpes
- ❒ Frequent Colds or Flu
- ❒ Hearing Problems
- ❒ Tonsilitis/Adenitis
- ❒ Tonsils Removed: Age: _____
- ❒ Adenoids Removed: Age: _____
- ❒ Athsma
- ❒ Mouthbreathing
- ❒ Emotional Problems

Do you require pre-medication for dental treatment? ❒ Yes ❒ No If so, what? _____

DENTAL HISTORY

Name and address of your general dentist? _____

When did you last see the dentist? _____ How often do you see the dentist? _____

Have you had any severe head or face injuries?	❒ Yes	❒ No	Explain:	_____
Have you had a history of thumb sucking or finger sucking?	❒ Yes	❒ No	Stopped? ❒ Yes ❒ No	
Do you play any musical (wind) instruments?	❒ Yes	❒ No	Which?	_____
Have you consulted an orthodontist previously?	❒ Yes	❒ No	Explain:	_____
Have you had any previous orthodontic treatment?	❒ Yes	❒ No	Explain:	_____

- ❒ Clenching Teeth
- ❒ Grinding Teeth
- ❒ Muscular Soreness around Head and Neck
- ❒ Headaches (more than normal)
- ❒ Jaw Joint Soreness
- ❒ Jaw Joint Clicking
- ❒ Jaw Joint Popping
- ❒ Ringing in the Ears

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

This office will assist you in filing your insurance. Services rendered are charged to the patient, not the insurance company, and patients are expected to take care of their fees as services are rendered or as specified in any signed contract.

6/99 THANK YOU! Signed: _____ Date: _____