ORTHODONTIC PATIENT ACQUAINTANCE FORM
(Adult)

Welcome to our office. We look forward to serving you. In order to provide an accurate diagnosis and the best possible treatment, we would appreciate your taking a few moments to answer the following questions. Information on this form will be held in confidence, and will be made available only to your physician, general dentist, or insurance company.

TODAY'S DATE_____

PATIENT INFORMATION

PATIENT'S NAME_____BIRTH DATE_____ AGE_____
LAST FIRST NICKNAME

HOME ADDRESS_____ HOME PHONE_____

_____ CELL PHONE_____

PHYSICIAN_____ GENERAL DENTIST_____

PATIENT'S INTEREST OR HOBBIES (OPTIONAL)_____

HAVE YOU OR OTHER FAMILY MEMBERS HAD PREVIOUS ORTHODONTIC TREATMENT (PLEASE DESCRIBE BRIEFLY)_____

MARITAL STATUS ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

HOW DOES YOUR SPOUSE FEEL ABOUT YOU HAVING ORTHODONTIC TREATMENT?_____

YOUR EMPLOYER_____OCCUPATION_____

BUSINESS ADDRESS_____TELEPHONE_____

SPOUSE'S NAME (IF MARRIED)_____

SPOUSE'S EMPLOYER_____OCCUPATION_____

BUSINESS ADDRESS_____ TELEPHONE_____

As you are probably aware, more and more adults are having orthodontic treatment today. Contrary to popular belief, there is very little which cannot be accomplished in adults just as well as in children or adolescents. We are pleased that you are giving us the opportunity to discuss just what modern orthodontic therapy can do for you.

WHAT ARE YOUR CONCERNS? WHAT WOULD YOU LIKE US TO ACCOMPLISH FOR YOU FROM AN ORTHODONTIC STANDPOINT?_____

WHO MAY WE THANK FOR REFERRING YOU?_____

MEDICAL HISTORY

1. Is the patient in good health?……YES NO
2. Any allergies or drug sensitivities? Please list _____YES NO
3. Have tonsils/adenoids been removed? At what age?_____……..YES NO
4. Does the patient have frequent (please check) ___colds ___sore throats ___ear infections?……..YES NO
5. Is the patient currently under the care of a physician? Reason _____YES NO
6. Is the patient currently taking any medications? Please list drug and condition requiring its use. _____YES NO
7. Has the patient had any major illnesses or operations? Please list and give approximate dates _____YES NO
8. Please review the following carefully, and circle any conditions for which the patient has been treated:

Rheumatic fever	Serious lung or respiratory disease	Hepatitis, jaundice, or liver disorder
Diabetes	Convulsions, seizures, or epilepsy	High or low blood pressure
Tuberculosis	Hyperactivity or learning disorder	Anemia or other blood disorder
Kidney trouble	Arthritis, bone, or joint problems	Fainting, dizziness, or nervous disorders
Heart trouble or murmurs	Endocrine (glandular) disorder	Glaucoma or serious eye disorder
Pneumonia	Asthma or hay fever	Frequent fever blisters or cold sores

9. Are there any special problems not listed above which you feel we should be made aware of?_____

_____

10. Approximate day of last physical examination_____

DENTAL HISTORY

1. Date of last dental examination_____ Is there any treatment needed?…..……YES NO
2. Have there been any injuries to the face, mouth, or teeth?……..YES NO
   Please list occurrence and approximate date _____
3. Has an orthodontist been consulted previously?……..YES NO
   Please give doctor and approximate date _____
4. Has the patient ever sucked __thumb __fingers __lip? Until what age?_____……YES NO
5. Does the patient have any speech problems?……..YES NO
6. Has the patient been given speech or tongue thrust therapy?……..YES NO
7. Have any baby teeth been extracted to help crowding or eruption problems?……YES NO
8. Have any teeth been lost due to decay or periodontal (gum) problems?……YES NO
9. Are you aware of any __ missing __extra __ impacted teeth which have not erupted into the mouth?……YES NO
10. Has the patient ever had any of the following temporomandibular (jaw) joint symptoms?……YES NO
    a. __ Clicking or popping of the joint when opening or closing.
    b. __ Pain in the area of the joint.
    c. __Jaw locking open or closed, or inability to open the mouth.
11. Do the patient's gums bleed frequently when brushing or has periodontal (gum) disease ever been diagnosed?……YES NO
12. Does the patient frequently clench or grind the teeth? (If so, please give details)_____ YES NO
13. Are you aware of tongue thrusting, lip biting, or any other adverse oral muscle habits? (If so, please give details)_____YES NO
    _____
14. Are there any other questions or facts you would like to discuss? Please list _____YES NO
    _____

INSURANCE INFORMATION

DENTAL INSURANCE __ YES __NO

INSURED'S NAME_____
SS#_____BIRTH DATE_____
EMPLOYER_____
INS. CO. /PLAN_____
UNION/GRP. NAME_____
GRP. OR POLICY #_____ LOCAL #_____
DATE EMPLOYED_____
AMOUNT OF ORTHODONTIC BENEFIT, IF KNOWN _____

ADDITIONAL DENTAL INSURANCE __ YES __ NO

INSURED'S NAME_____
SS#_____BIRTHDATE_____
EMPLOYER_____
INS. CO. /PLAN_____
UNION/GRP.NAME_____
GRP. OR POLICY #_____LOCAL #_____
DATE EMPLOYED_____
AMOUNT OF ORTHODONTIC BENEFIT, IF KNOWN_____

Signature of person filling out this form_____Relationship_____

PLEASE DO NOT WRITE BELOW THIS LINE

DATE	PROCEDURE	DIAGNOSES	NEXT VISIT