

# Orthodontic Acquaintance – PERSONAL INFORMATION

Date Today: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Name of Family Physician: \_\_\_\_\_

Whom can we thank for referring you to this office? \_\_\_\_\_

## Information for ADULT Patients:

Place of Business: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ 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: \_\_\_\_\_

### Please check if you have had any of the following:

- |                              |                             |                        |                              |                             |                    |                              |                             |                            |
|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|--------------------|------------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Frequent Colds or Flu      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Disease          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Problems           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Prolonged Bleeding     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsillitis/Adenitis       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Endocrine Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tonsils Removed Age: ____  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS antibody positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone Disorders     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Adenoids Removed Age: ____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jaundice               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Herpes             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mouthbreathing: _____      |
|                              |                             |                        |                              |                             |                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emotional Problems         |

## Dental History

Name and address of your general dentist: \_\_\_\_\_

When did you last see the dentist: \_\_\_\_\_

Yes  No Have you had any severe head or face injuries? Explain: \_\_\_\_\_

Yes  No Have you had a history of thumb sucking or finger sucking? Stopped: \_\_\_\_\_

Yes  No Do you play any musical (wind) instruments? What? \_\_\_\_\_

Yes  No Have you consulted an orthodontist previously? \_\_\_\_\_

Yes  No Have you had an previous orthodontic treatment? \_\_\_\_\_

### Please check if there is a history of:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Clenching Teeth                      | <input type="checkbox"/> Headaches (more than normal) | <input type="checkbox"/> Jaw Joint Popping   |
| <input type="checkbox"/> Grinding Teeth                       | <input type="checkbox"/> Jaw Joint Soreness           | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Muscular Soreness around Head & Neck | <input type="checkbox"/> Jaw Joint Clicking           |  |

Is there any other information that may be helpful? \_\_\_\_\_

Why are you seeking orthodontic consultation? \_\_\_\_\_

Person responsible for payment of account? \_\_\_\_\_

Insurance Company: \_\_\_\_\_

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.

Thank you

Signed: \_\_\_\_\_ Date: \_\_\_\_\_