

# ADULT ORTHODONTIC ACQUAINTANCE FORM

Your Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Years \_\_\_\_\_ Months Sex \_\_\_\_\_ M \_\_\_\_\_ F

Address: Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Residence (\_\_\_\_\_) \_\_\_\_\_ Marital Status \_\_\_\_\_

Employed By/Occupation \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Employed By/Occupation \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Do you have insurance for orthodontic treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which company? \_\_\_\_\_ S.S. # \_\_\_\_\_

## I. MEDICAL HISTORY:

Family Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Have you ever had:

Y N AIDS	Y N Bleeding	Y N Epilepsy	Y N Injury to Face/Head
Y N Anemia	Y N Cerebral Palsy	Y N Hearing Problem	Y N Kidney Disease
Y N Arthritis	Y N Cold Sores	Y N Heart Condition	Y N Lung Disease
Y N Asthma	Y N Diabetes	Y N Hepatitis	Y N Oral Ulcers
Y N TB	Y N Rheumatic Fever	Y N Sore or clicking jaw joints	

Other illness or operations \_\_\_\_\_

Are you receiving any medication? \_\_\_\_\_ Yes \_\_\_\_\_ No

List any allergies or drug sensitivities \_\_\_\_\_

Do you need to be premedicated (antibiotics) for routine dental procedures? \_\_\_\_\_

Specify and describe \_\_\_\_\_

## II. DENTAL HISTORY:

Family Dentist \_\_\_\_\_ Date of last dental examination \_\_\_\_\_

Injury or trauma to the teeth or gums? \_\_\_\_\_ Yes \_\_\_\_\_ No Describe \_\_\_\_\_

Have you ever had previous orthodontic consultation and/or treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, describe \_\_\_\_\_ By whom \_\_\_\_\_

Has any member of your family had orthodontic treatment? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you grind your teeth? \_\_\_\_\_ Yes \_\_\_\_\_ No Bite your fingernails? \_\_\_\_\_ Yes \_\_\_\_\_ No

Describe the main reason why you are seeking orthodontic treatment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_



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