ADULT ORTHODONTIC ACQUAINTANCE CARD

Patient's Name: Date:
Last First Middle Initial Nickname
Birthdate: Age: Sex: Home Phone( ) -
Address: Cell Phone( ) -
City: St: Zip:
Patient's Dentist: Referred by:
Employed by: Position Held: Soc.Sec.# - -
Business Address: Bus.Phone( ) -
Spouse's Name: Birthdate:
Address(if different): Cell Phone( ) -
Employed by: Position Held: Soc.Sec.# - -
Business Address: Bus.Phone( ) -
Person Responsible for Account:
Names and Ages of Children in Family:

MEDICAL HISTORY

Is patient in good health? (circle one) Yes or No
Does patient have any history of major illness? Yes or No
Is the patient presently under the care of a physician for a major illness? Yes or No Physician name:
Please list the major illness:
Do you experience: Frequent headaches? Yes or No Chronic neck or shoulder pain? Yes or No
Aches or pain on the side(s) of your face? Yes or No

Check any of the following for which the patient has been treated:

____Diabetes
____Rheumatic Fever
____Heart Trouble/Abnormalities
____Fainting or Dizziness
____Hepatitis
____Epilepsy or Seizures
____Asthma
____Kidney Problems
____Nervous Disorders
____Tuberculosis
____Pneumonia
____Bone Disorders
____Endocrine Problems
____Prolonged Bleeding
____HIV / AIDS
____Drug/Alcohol Abuse
____Cancer/Chemotherapy
____Radiation Treatment
____Artificial Joints / Valves
____Psychiatric problems

Does patient have a tendency to colds? Yes or No Sore throats? Yes or No Ear infections? Yes or No
Have the tonsils and adenoids been removed? Yes or No If Yes, at what age?
List any drugs or medications now being taken and reasons being taken:

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonates? What and When?

List any allergies or drug sensitivity:

DENTAL HISTORY

Have there been injuries to the face? Yes or No Mouth? Yes or No Teeth? Yes or No
Does the patient have any speech problems? Yes or No
Is the patient a mouth breather? Yes or No While awake? Yes or No While asleep? Yes or No
Are you aware of clenching or grinding your teeth during the day or night? Yes or No
Have you been informed of any missing or extra permanent teeth? Yes or No
Has an orthodontist been consulted previously? Yes or No
Have you had any previous orthodontic treatment? Yes or No
If Yes, when? For what?
Have you had previous gum treatment? Yes or No Do your gums bleed on brushing? Yes or No
What are the main concerns that you would like orthodontic treatment to address?

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Patient Signature