ADULT ORTHODONTIC ACQUAINTANCE CARD E-Mail_________________________________Date______________.

PATIENTS NAME (L.)_______________________________(F) ____________________ (M.I.) _____ (Ext.)______DOB___/___/___.

ADDRESS ____ZIP_____________.

HOME PHONE(____) ____________________BUS. PHONE_____________________________SS ________ - _______ -_________.

EMERGENCY CONTACT____ PHONE(___)_______________________.

INSURANCE: YES ☐ NO ☐ NAME:_______________________________MAR. STAT.: S M D W PREGNANT: YES ☐ NO ☐

PHYSICIAN____________________________________DENTIST__________________________ REF_______________☐.

OCCUPATION____ O.K. TO CONTACT: YES ☐ NO ☐

EMPLOYER____H.P. (___)________________B.P.(___)____________.

RESPONSIBLE PARTY(LIVES WITH WHOM?) F M S O FINANCIAL RESPONSIBILITY: F M S O

NAMES AND BIRTHDATES OF CHILDREN (18)____.

MEDICAL HISTORY

ARE YOU IN GOOD HEALTH? ____YES ☐ NO ☐

DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS? ______________________________________YES ☐ NO ☐

HAVE YOU EVER BEEN UNDER THE CARE OF PHYSICIAN FOR ILLNESS? ___________________YES ☐ NO ☐

PLEASE LIST:____.

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

EYE/EAR/NOSE	☐ Y ☐ N	PNEUMONIA/RESPIRATORY	☐ Y ☐ N	RECENT LOSS OF WEIGHT	☐ Y ☐ N
ASTHMA	☐ Y ☐ N	PROLONG BLEEDING	☐ Y ☐ N	CANCER TREATMENT	☐ Y ☐ N
DIABETES	☐ Y ☐ N	SEIZURES/NEUROLOGICAL	☐ Y ☐ N	JOINT PROSTHETICS	☐ Y ☐ N
TUBERCULOSIS	☐ Y ☐ N	BIRTH DEFECTS/ HEREDITARY PROBLEMS	☐ Y ☐ N	KIDNEY PROBLEMS	☐ Y ☐ N
SKIN DISORDERS	☐ Y ☐ N	MENTAL/ANXIETY HEALTH DISORDERS	☐ Y ☐ N	RHEUMATIC FEVER	☐ Y ☐ N
SENSE OR SPEECH	☐ Y ☐ N	BONE FRACTURES/MAJOR ACCIDENTS	☐ Y ☐ N	AUTOIMMUNE DISORDER	☐ Y ☐ N
HYPERTENSION/HEART	☐ Y ☐ N	HEADACHES/ COLDS/ SORE THROAT	☐ Y ☐ N	FAINTING OR DIZZINESS	☐ Y ☐ N
HEPATITIS/LIVER	☐ Y ☐ N	CHEST PAIN/SHORTNESS OF BREATH	☐ Y ☐ N	EATING DISORDERS	☐ Y ☐ N
CARDIOVASCULAR	☐ Y ☐ N	ENDOCRINE/THYROID PROBLEMS	☐ Y ☐ N	TONSILS REMOVED	☐ Y ☐ N

TAKING ANY PRESCRIPTION MEDICATION, SUPPLEMENTS, HERBAL MEDICATIONS OR NON-PRESCRIPTION MEDICATIONS? ☐ Y ☐ N

PLEASE LIST:

DO YOU HAVE TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐ LATEX ALLERGY ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE?_____________________________YES ☐ NO ☐

LIST ANY ALLERGIES OR DRUG SENSITIVITY:____

____.

HEIGHT____________________ WEIGHT___________________.

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?____________________________YES ☐ NO ☐

HAVE YOU EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE?_______________________ YES ☐ NO ☐

DO YOU HAVE ANY SPEECH PROBLEMS?____.

ARE YOU A MOUTH BREATHER? WHILE AWAKE OR ASLEEP?___________________________________YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING PERMANENT TEETH? ____________________ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?_______________________________________YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?____YES ☐ NO ☐

HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE,T.M.J., DENTAL ISSUES?_______________ YES ☐ NO ☐

REASON FOR CONSULTATION:____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

______________________________ ____________ ______________________________

(Patient/Parent/Guardian) Signature Date (Patient/Parent/Guardian) Signature Date

______________________________ ____________ ______________________________

(Patient/Parent/Guardian) Signature Date (Patient/Parent/Guardian) Signature Date