ADULT
ORTHODONTIC ACQUAINTANCE FORM

DATE _____ 20____

DATE OF BIRTH_____

PATIENT'S NAME _____ AGE _____ SEX _____
LAST FIRST MIDDLE

RES. ADDRESS _____ PHONE _____
STREET CITY STATE ZIP

EMPLOYED BY _____ OCCUPATION _____

BUS. ADDRESS _____ BUS./CELL PHONE _____

REFERRED BY _____ PATIENT'S S.S.NO. _____

PATIENT'S DENTIST _____ PHYSICIAN _____

SPOUSE'S NAME _____ MARRIED/SEPARATED/DIVORCED/WIDOWED _____

EMPLOYED BY _____ OCCUPATION _____

BUS. ADDRESS _____ BUS.PHONE _____

DO YOU HAVE DENTAL INSURANCE? _____ IF YES, WITH WHOM _____

MEDICAL HISTORY

DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS?..... ☐ YES ☐ NO

PLEASE LIST ANY ALLERGIES: _____

LIST ANY DRUG SENSITIVITIES: _____

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

☐ DIABETES	☐ TUBERCULOSIS	☐ ENDOCRINE PROBLEMS
☐ PNEUMONIA	☐ ANEMIA	☐ PROLONGED BLEEDING
☐ HEART TROUBLE	☐ EPILEPSY	☐ FAINTING OR DIZZINESS
☐ RHEUMATIC FEVER	☐ ASTHMA	☐ NERVOUS DISORDERS
☐ BONE DISORDERS	☐ SICCA	☐ GLAUCOMA

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASON: _____

_____ DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

DENTAL HISTORY

DATE OF LAST DENTAL EXAMINATION_____ IS WORK COMPLETED?..... ☐ YES ☐ NO

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

ARE YOU HAVING ANY DENTAL PAIN?..... ☐ YES ☐ NO

DO YOU HAVE ANY JAW JOINT (LOCATED IN FRONT OF THE EAR) PAIN OR CLICKING?..... ☐ YES ☐ NO

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

HAVE YOU HAD ORTHODONTIC TREATMENT BEFORE?..... ☐ YES ☐ NO

HAS ANOTHER ORTHODONTIST BEEN CONSULTED RECENTLY? ..... ☐ YES ☐ NO

WHAT DO YOU CONSIDER TO BE THE MAIN BENEFITS OF ORTHODONTIC CORRECTION? CHECK ONE OF THE FOLLOWING: COSMETIC _____ FUNCTIONAL _____ PSYCHOLOGICAL/EMOTIONAL OTHER _____

REASON FOR CONSULTATION: _____

email _____ _____

PATIENT'S SIGNATURE

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