ORTHODONTIC ACQUAINTANCE FORM

PRACTICE LIMITED TO ORTHODONTICS

DATE _____

NAME _____ NICKNAME _____

AGE _____ BIRTHDATE _____ SEX _____ SOCIAL SECURITY# _____

HOME ADDRESS _____ HOME PHONE _____

_____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

_____

SPOUSE'S NAME _____ BUSINESS PHONE _____

PERSON RESPONSIBLE FOR PAYMENT _____

DO YOU HAVE ORTHODONTIC INSURANCE? _____ IF YES, NAME OF CARRIER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTIST _____ PHONE _____ DATE OF LAST VISIT _____

HOW WOULD YOU DESCRIBE YOUR ORAL HYGIENE _____

HAVE YOU HAD A PREVIOUS ORTHODONTIC CONSULTATION? _____

HAS ANY RELATIVE HAD ORTHODONTIC TREATMENT? _____ IF YES, RELATIONSHIP _____

HAVE YOU EVER HAD ANY INJURY TO YOUR TEETH OR HEAD? _____

IF YES, EXPLAIN _____

_____

HAVE YOU EVER UNDERGONE SPEECH OR MYOFUNCTIONAL THERAPY? _____

HAVE YOU EVER EXPERIENCED PAIN OR DISCOMFORT IN YOUR JAW JOINT? _____

IF YES, EXPLAIN _____

HAVE YOU EVER EXPERIENCED ANY FACIAL PAIN OR DISCOMFORT? _____

IF YES, EXPLAIN _____

DO YOU HAVE ANY OF THE FOLLOWING HABITS? PLEASE CHECK ANY THAT APPLY

FINGER SUCKING _____ NAIL BITING _____ LIP BITING _____ PENCIL/OBJECTS BITING _____

MOUTH BREATHING _____ GRINDING OF TEETH _____ OTHER _____

DESCRIBE WHAT YOU WOULD LIKE US TO ACCOMPLISH FOR YOUR YOU _____

_____

MEDICAL HISTORY

YOUR PHYSICIAN_____ _____ PHONE_____

ADDRESS_____

ARE YOU PRESENTLY IN GOOD HEALTH?_____HAVE YOU BEEN UNDER A

PHYSICIANS CARE IN THE LAST 5 YEARS?_____IF YES, PLEASE EXPLAIN _____

_____

_____

ARE YOU TAKING ANY MEDICATION AT THE PRESENT TIME?_____ IF YES, PLEASE LIST

MEDICATION AND REASON: _____

_____

_____

ARE YOU ALLERGIC TO LATEX?_____ ARE YOU ALLERGIC TO ANY DRUGS?_____

PENICILLIN?_____ OTHERS?_____

DO YOU HAVE A HISTORY OF HEART DISEASE_____VENEREAL DISEASE_____ASTHMA _____

BLEEDING TENDENCIES _____ EPILEPSY/SEIZURES _____ HEPATITIS _____HIV+/AIDS _____

ENDOCRINE (GLAND) DISORDERS _____RHEUMATIC FEVER _____SCARLET FEVER _____

HIGH/LOW BLOOD PRESSURE _____DIABETES _____SEVERE/FREQUENT HEADACHES _____

PLEASE NOTE ANY OTHER MEDICAL PROBLEMS_____

_____

_____

_____

OTHER RELEVANT INFORMATION _____

_____

_____

_____

SIGNATURE DATE