ADULT ORTHODONTIC ACQUAINTANCE SHEET

DATE OF EXAM _____
DATE OF BIRTH _____

PATIENT'S NAME: _____ AGE: _____ SEX: _____
LAST FIRST M.I.

ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

E-MAIL ADDRESS: _____ CELL PHONE: _____

PATIENT'S DENTIST: _____ PHYSICIAN: _____ REFERRED BY: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____ RELATIONSHIP: _____

LIST INSURANCE PLAN COVERING ORTHODONTIC TREATMENT (IF ANY): _____

PATIENT'S OCCUPATION: _____ EMPLOYED BY: _____ BUS. PHONE: _____

SPOUSE'S NAME (IF MARRIED): _____ EMPLOYED BY: _____ BUS. PHONE: _____

PATIENT'S SLEEPING POSTURE: ☐ ON BACK ☐ ON FACE ☐ ON LEFT SIDE ☐ ON RIGHT SIDE ☐ RESTLESS SLEEPER

ANY BIRTH DEFECTS? _____ PLEASE LIST: _____

MEDICAL HISTORY

Height: _____ Weight: _____ Is patient in good health? _____ ☐ Yes ☐ No

Does patient have a history of any major illness? _____ ☐ Yes ☐ No

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 DISORDER ..... [ ]	KIDNEY INVOLVEMENT ..... [ ]	LIVER INVOLVEMENT ..... [ ]

Have you been under the care of a physician for a major illness? _____ ☐ Yes ☐ No

Do you have a tendency for: ☐ colds ☐ sore throats ☐ ear infections _____ ☐ Yes ☐ No

Have your tonsils and adenoids been removed? ☐ Yes ☐ No What Age? _____

Any broken bones? Please explain: _____ ☐ Yes ☐ No

List any drug allergies or sensitivity: _____

Do you bleed easily? _____ ☐ Yes ☐ No

Did you have a high fever associated with any childhood diseases? _____ ☐ Yes ☐ No

Any psychological counseling? _____ ☐ Yes ☐ No

DENTAL HISTORY

Have you had any injuries to the face or mouth? Date: _____ ☐ Yes ☐ No

Have you ever sucked your thumb or finger? Until what age? _____ ☐ Yes ☐ No

Any lip or nail biting? _____ Other? _____ ☐ Yes ☐ No

Do you have any speech problems? _____ ☐ Yes ☐ No

Are you a mouth breather? ☐ While awake ☐ While asleep _____ ☐ Yes ☐ No

Are your lips apart often? _____ ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

List any musical instruments played with the lips or mouth: _____

List sports or hobbies: _____

Do you vomit, gag or faint easily? _____ ☐ Yes ☐ No

Any pain on or near your ears? ☐ Right ☐ Left _____ ☐ Yes ☐ No

Any apprehensive or unfavorable experience in a dental office? _____ ☐ Yes ☐ No

Have you ever been placed on an oral hygiene program by a dentist? _____ ☐ Yes ☐ No

When was your last visit to a dentist? _____ Date of last X-rays: _____

Do you complete work assigned to do? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

Most Important: Do you want orthodontic treatment? _____ ☐ Yes ☐ No

What do you wish to gain by orthodontic treatment? _____

Signature of Patient: _____ Date: _____