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Specialist in Orthodontics

Member American Association of Orthodontists

DIPLOMATE
AMERICAN BOARD
OF ORTHODONTICS

Welcome to our office! We are honored that you have chosen us to care for you and we look forward to serving you. It is our desire to address your concerns about your bite problem (or "malocclusion") during your first visit, which we call the examination.

This information acquaintance form will allow us to know more about you. In our office, we want to treat you first and your teeth second.

PERSONAL INFORMATION

Today's Date: / /

Patient's Name: _____
Last Name First Name Middle Name you prefer to be called

Date of Birth: / / Age: _____ yrs. Sex: _____

Home Address: _____ Phone: _____
Street City Zip

Patient's Dentist: _____ Patient's Doctor: _____

Were you referred to us?.....YES ☐ NO ☐ If YES, by whom? _____

Do you want orthodontic treatment?.....YES ☐ NO ☐

List your hobbies or special interests: _____

Favorite Movie: _____ Music: _____ TV Show: _____

MEDICAL HISTORY

Have you ever had:

Heart Trouble..... YES ☐ NO ☐	Glaucoma.....YES ☐ NO ☐	Broken Bones..... YES ☐ NO ☐
Liver Trouble.....YES ☐ NO ☐	Convulsions.....YES ☐ NO ☐	Diabetes..... YES ☐ NO ☐
Bleeding Problems..... YES ☐ NO ☐	Contact Lenses....YES ☐ NO ☐	Rheumatic Fever.....YES ☐ NO ☐
Hay Fever, Asthma,.....YES ☐ NO ☐ or Allergies	Tonsilitis.....YES ☐ NO ☐	Positive HIV test.....YES ☐ NO ☐

Are you in good health now?..... YES ☐ NO ☐

Have you ever had another serious illness, accident or condition?.....YES ☐ NO ☐

If YES, please list: _____

List any drugs or medications now being taken: _____

List allergies to any drugs or medications: _____

Have your tonsils or adenoids been removed?.....YES ☐ NO ☐

If YES, at what age? _____

Have you experienced excessive changes in weight in the last 6 months?.....YES ☐ NO ☐

Do you snore at night?.....YES ☐ NO ☐

Do you grind your teeth at night?.....YES ☐ NO ☐

Do you breathe predominantly through your mouth?.....YES ☐ NO ☐

Do you have any missing or extra teeth?..... YES ☐ NO ☐

Have you had any traumatic dental examinations?.....YES ☐ NO ☐

If YES, at what age? _____

Have you had a previous orthodontic examination?.....YES ☐ NO ☐

When was your last dental examination? / /

Do your gums bleed when brushed?.....YES ☐ NO ☐

Have you ever received a severe blow to the head or jaw?.....YES ☐ NO ☐

If YES, when? _____

Have any of your teeth needed to be removed by your dentist?..... YES ☐ NO ☐

How often do you brush your teeth? _____

Did you ever suck your fingers, lip or another object?.....YES ☐ NO ☐

If stopped, at what age? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ # years employed _____

Spouse's Name

_____
Last First Middle

Spouse's
Employer _____

Occupation _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's ID/SS# _____

Employer _____ Group # _____

Insurance Company Name: _____ Phone # _____

Insurance Company Address: _____

_____

Emergency Contact Information

Emergency Contact Name: _____

Phone # _____

I hereby agree that, to the best of my knowledge, the above information is true.

_____ _____
Signature **Date**