MODEL NO. DATE:

ADULT ORTHODONTIC ACQUAINTANCE FORM

Last Name:_____First:_____ Middle Initial:_____

Date of Birth: _____ Age: _____ ❑ Male ❑Female

Home Address: _____

City:_____ Province: _____ Postal Code: _____ Home Phone: _____

Work Address: _____ Work Phone: _____Occupation: _____

Spouses Name(if applicable):_____ Work Phone: _____ Occupation: _____

Name of Dentist: _____ Name of Physician & Telephone: _____

Person responsible for Account(self, other?): _____Phone #: _____

Address: _____ Insurance Coverage: ❑Yes ❑No

How did you hear about this office?: _____

MEDICAL HISTORY

A thorough and complete history is vital to a proper Orthodontic evaluation. All answers are for office records only and will be considered confidential. If you are unsure or don't completely understand the question please circle "dk/u" (don't know/unsure).

Yes	No	dk/u	Have you been treated for any **medical condition** within the last year?	Yes	No	dk/u	Have you ever had Diabetes, Thyroid Disorder, Asthma, Arthritis, a Blood or Bleeding disorder or Epilepsy?
Yes	No	dk/u	Are you taking any **medication**?				
Yes	No	dk/u	Have you ever been **hospitalized** for an **operation** or **serious illness**?	Yes	No	dk/u	Do you or have you Smoked or chewed tobacco?
Yes	No	dk/u	Do you have any **Allergies**?	Yes	No	dk/u	Do you have an artificial joint or valve?
Yes	No	dk/u	Is there a history of **Rheumatic fever**, **Heart Murmur** or Mitral Valve Prolapse?	Yes	No	dk/u	Have you ever been treated for Venereal Disease?
Yes	No	dk/u	Ever have or tested positive for HIV or AIDS?	Yes	No	dk/u	Do you have high blood pressure?
				Yes	No	dk/u	(Women) Are you pregnant? Due_____
Yes	No	dk/u	Any general health change in last year?	Yes	No	dk/u	Do you have a Kidney Disorder?
Yes	No	dk/u	Have you ever been treated for or had heart disease or a heart attack?	Yes	No	dk/u	Have you ever had Hepatitis, Jaundice or a Liver Disorder?
				Yes	No	dk/u	Any other medical condition?

If you responded yes to any of the above, please give pertinent details:_____

_____

_____

Continued on other side

DENTAL HISTORY

Yes No dk/u Have you had any injuries to the face, jaw, mouth or teeth?
Yes No dk/u Have you ever sucked you thumb or finger? Until what age?_____
Yes No dk/u Do you have any speech problems?
Yes No dk/u Are your teeth sensitive to hot or cold?
Yes No dk/u Have you ever been treated for "TMJ" problems?
Yes No dk/u Does your jaw become sore or stiff?
Yes No dk/u Do you grind your teeth or clench your jaw?
Yes No dk/u Do you have difficulty chewing or opening your mouth?
Yes No dk/u Do you chew gum regularly?
Yes No dk/u Have you had orthodontic treatment before?
Yes No dk/u Have any of your teeth been removed?
Yes No dk/u Have you been told you have supernumerary(extra) teeth or congenitally missing teeth?
Yes No dk/u Does any relative have a similar tooth or jaw relationship?
Yes No dk/u Do you visit your dentist regularly? How often? _____

How often do you brush?_____ Floss?_____

What is your primary concern – Why are you here? _____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his 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.

_____
Signature of Patient Date

_____
Reviewed by Orthodontist Date

MEDICAL HISTORY UPDATES OR CHANGES

_____
_____
_____
_____
_____