ADAMS ORTHODONTICS

Adult
Orthodontic Acquaintance Form

Your name_____

Date of birth _____ Age ___ Years ___ Months Sex __ M __ F

Address _____

City _____ State _____ Zip_____

Telephone: (_____) _____ Daytime/work (_____) _____ Cell (_____) _____

Employed by/Occupation _____

Spouse's name _____ Employed by _____

Do you have insurance for orthodontic treatment? ___ Y ___ N

If yes, which company? _____ SS#/ID# _____

I. MEDICAL HISTORY

Family physician _____ Phone (_____) _____

Have you ever had:

___ HIV	___ TB	___ Kidney disease	___ Cold sores
___ Anemia	___ Diabetes	___ Heart condition	___ Oral ulcers
___ Bleeding	___ Epilepsy	___ Cerebral palsy	___ Injury to face/head
___ Asthma	___ Hepatitis	___ Rheumatic fever	___ Sore/clicking jaw joints
___ Arthritis	___ Lung disease	___ Hearing problems	___ Latex allergy

Other illness or operations: _____

Are you receiving any medications? ___ Y ___ N List _____

_____

List any allergies or drug sensitivity _____

Do you need to be premedicated (antibiotics) for routine dental procedures? ___ Y ___ N

Specify and describe _____

II. DENTAL HISOTRY

Family dentist: _____ Date of last dental examination_____

Injury or trauma to the teeth or gums ? ___ Y ___ N Describe_____

Have you ever had previous orthodontic consultation and/or treatment ? ___ Y ___ N

If yes, describe _____ by whom _____

Has any member of the family had orthodontic treatment? ___ Y ___ N

Do you grind your teeth? ___ Y ___ N Bite your fingernails? ___ Y ___ N

Describe the main reason why you are seeking orthodontic treatment _____

_____

Signature _____ Today's Date_____

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