ACQUAINTANCE FORM

Patient's Name _____ Nickname _____
Address _____ City _____ Zip _____
Home Phone _____ Birthdate _____
Hobbies and Interests _____ SS# _____

Employed by _____ Occupation _____
Business Address _____ Business Phone _____

Spouse's Name _____ SS# _____
Employed by _____ Occupation _____
Business Address _____ Business Phone _____

ORTHODONTIC INSURANCE INFORMATION

Primary Coverage:
Name of Insured (Employee) _____ Birthdate _____
Name of Insurance Company _____ Group # _____
Insurance Billing Address _____ City _____ Zip _____
Insurance Phone Number _____

Secondary Coverage:
Name of Insured (Employee) _____ Birthdate _____
Name of Insurance Company _____ Group # _____
Insurance Billing Address _____ City _____ Zip _____
Insurance Phone Number _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

	Yes	No	
Have you experienced any health problems?		___	_____
Any major change in your health recently?	___	___	_____
Are you currently under a physician's care?	___	___	_____
Are you taking medications regularly?	___	___	_____
Are you allergic to any medications?	___	___	_____
Have your tonsils or adenoids been removed?	___	___	_____

Please check if you now have or have ever had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Heart Murmur	___	___	Sinus Problems	___	___	Blood Pressure Problems	___	___
Heart Surgery	___	___	Hepatitis	___	___	Frequent Headaches	___	___
Rheumatic Fever	___	___	Diabetes	___	___	Nervous Disorders	___	___
Herpes	___	___	Kidney Disease	___	___	Fainting or Dizziness	___	___
AIDS or ARC	___	___	Liver Disease	___	___	Bone Disorders	___	___
Anemia	___	___	Tuberculosis	___	___	Growth Disorders	___	___
Blood Disease	___	___	Asthma	___	___	Prolonged Bleeding	___	___

Is there any other condition or problem that you feel we should be aware of? _____
_____
_____

-over please-

DENTAL HISTORY

Your general dentist: _____
Frequency of dental checkups: ___ Never ___ Only if a problem exists ___ Once a year ___ Twice a year
Date of last checkup and cleaning _____

	Yes	No	
Is there any dental work to be completed with your general dentist?	___	___	_____
Have you had any face or dental injuries?	___	___	_____
Do you have any speech problems?	___	___	_____
Do you breathe through your mouth more than your nose?	___	___	_____
Is there any history of thumb or finger sucking?	___	___	_____
Have you been informed of any missing or extra teeth?	___	___	_____
Is there any history of gum disease?	___	___	_____
Do your gums bleed frequently when you brush your teeth?	___	___	_____
Do you bite your fingernails?	___	___	_____

Please check if there is a history of the following conditions:

___ Clenching teeth ___Muscular soreness around head & neck ___ Jaw joint soreness ___ Jaw joint popping
___ Grinding teeth ___ Headaches (more than normal) ___ Jaw joint clicking ___ Recurrent ringing in ears

Please describe your orthodontic problem and concerns:_____
_____
_____
_____
_____

Have you ever had an orthodontic exam before? _____ When?_____With?_____
Have you ever had any orthodontic treatment before?_____If yes, please explain _____
_____

To the best of my knowledge, all of the preceding answers are true and accurate. If I ever have any change in health or change in medication, I will inform the orthodontist at the next appointment. The information on this form may be used to establish my credit.

Signature of patient _____ Date _____
_____

****

OFFICE USE

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____