ADULT ORTHODONTIC ACQUAINTANCE FORM

Name:____

Date of Birth: (D/M/Y)______________________ Age: ___________________________ Sex: Male / Female

Home Address: _______________________________________ City: ______________ Postal Code: __________

Business Address: ____________________________________ City: ______________ Postal Code: __________

Telephone: (_____) _________________________ Business Telephone: (_____) _______________

Email Desired for Contact**:** ____

Patient's Dentist: ______________________________ Referred by:_____________________________________

Person responsible for account: ____

Their Address: _______________________________________ City: ______________ Postal Code: __________

Do you have an insurance plan that covers orthodontic treatment? (please circle) Yes No Unsure

Reason for orthodontic consultation? ____

____

MEDICAL HISTORY

Have you ever been treated for any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Murmur			Artificial Joints (Hip, Knee, etc.)			High Blood Pressure			Kidney Disorder		
Mitral Valve Prolapse			Tuberculosis			Blood Disease			Asthma		
Rheumatic Fever			Radiation Therapy			Anemia			Arthritis		
Heart Disease			H.I.V./A.I.D.S.			Prolonged Bleeding			Thyroid Disorders		
Artificial Heart Valve			Diabetes			Hepatitis A, B, or C			Other:		
			Endocrine Problems								

If YES to any of the above, please give pertinent information:_________________________

____

Family Physician:_____________________________________ Telephone No:(____) ______________________

Are you in good health? Yes / No If no, please explain: ____

Do you have any history of major illnesses and/or operations?____

____

List any drugs or medication now being taken: Please give reasons: ____________________________________

____

List any allergies or drug sensitivities: ____

Do you have a tendency to colds? Yes / No Sore throats? Yes / No Ear infections? Yes / No

Have your tonsils or adenoids been removed? Yes / No If yes, when ? _________________________________

(Women) Are you pregnant ? Yes / No ____

DENTAL HISTORY **(Please circle)**

Have there been any injuries to the face, mouth, or teeth ?	YES	NO
Have you ever sucked a thumb or finger? Until what age ?________________	YES	NO
Do you have any speech problems ?	YES	NO
Do you have frequent canker or cold sores ?	YES	NO
Are you a mouth breather ? (If yes please circle): While asleep ? or awake ? or both ?	YES	NO
Have you been informed of any missing or extra baby or permanent teeth ?	YES	NO
Have you ever been treated for a jaw joint problem, including surgery ?	YES	NO
Have you ever had a previous orthodontic examination ? With whom ? _______________	YES	NO
Do you want orthodontic treatment ?	YES	NO

When did you last see your family dentist ?____

I hereby consent that Dr. Ziedenberg may release any information to my insurance carrier and/or Dentist as may be necessary for complete treatment of the above named patient. I hereby certify that the above information is complete and correct to the best of my knowledge.

Patient Signature: ____ **Date:** __________________________