ADULT ORTHODONTIC ACQUAINTANCE FORM

Name:_____

Date of Birth: (D/M/Y)_____ Age: _____ Sex: Male / Female / Other

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's Signature: _____ **Date:** _____