ADULT AQUAINTANCE FORM TODAY'S DATE:_____

SEX: M OR F

NAME:_____DATE OF BIRTH:_____
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS:_____CITY:_____ZIP CODE:_____

HOME PHONE: _____ CELL PHONE:_____

EMAIL ADDRESS:_____
CAN WE CONFIRM APPOINTMENTS BY EMAIL? YES NO

WHO MAY WE CONTACT IN CASE OF EMERGENCY?_____PHONE_____

WHO MAY WE THANK FOR REFERRING YOU? _____

WHO IS YOUR GENERAL DENTIST? NAME:_____PHONE#:_____

WHO IS YOUR PHYSICIAN? NAME:_____PHONE#:_____

_____

MEDICAL/DENTAL HEALTH INFORMATION PLEASE CIRCLE YES OR NO

DO YOU HAVE A HISTORY OF MAJOR ILLNESS? YES NO
IF YES, PLEASE EXPLAIN:_____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO
IF YES, PLEASE EXPLAIN:_____

ARE YOU CURRENTLY UNDER PSYCHIATRIC/EMOTIONAL CARE? YES NO
IF YES, PLEASE EXPLAIN:_____

HAVE YOU HAD YOUR TONSILS AND/OR ADENOIDS REMOVED? YES NO
IF YES, AT WHAT AGE?_____

ARE YOU TAKING ANY DRUGS OR MEDICATIONS? YES NO
IF YES, PLEASE LIST MEDICATIONS AND DOSAGE

_____

_____

DO YOU HAVE ANY ALLERGIES? YES NO
IF YES, PLEASE LIST:

_____

_____

PLEASE COMPLETE OTHER SIDE

PLEASE CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN OR ARE CURRENTLY BEING TREATED:

- ☐ DIABETES
- ☐ RHEUMATIC FEVER
- ☐ ANEMIA
- ☐ KIDNEY DISORDERS
- ☐ GLAUCOMA
- ☐ NERVOUS DISORDERS
- ☐ PNEUMONIA
- ☐ BONE DISORDERS
- ☐ ASTHEMA
- ☐ EPILEPSY
- ☐ ENDOCRINE PROBLEMS
- ☐ LIVER INVOLVEMENT
- ☐ COMPROMISED IMMUNE SYSTEM
- ☐ HEART TROUBLE
- ☐ TUBERCULOSIS
- ☐ PROLONGED BLEEDING
- ☐ FAINTING OR DIZZINESS

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE FREQUENTLY:

- ☐ COLDS
- ☐ SORE THROATS
- ☐ EAR INFECTIONS
- ☐ RESPIRATORY INFECTIONS
- ☐ CLENCHING/GRINDING OF THE TEETH IF YES, WHEN _____
- ☐ JAW PAIN
- ☐ BLISTERS ON MOUTH OR LIPS IF YES, WHERE_____
- ☐ CLICKING OR POPPING OF JAW IF YES, WHICH SIDE LEFT RIGHT (CIRCLE)
- ☐ CANKER SORES

HAVE YOU EVER SUCKED YOUR THUMB OR FINGERS? YES NO
IF YES, TO WHAT AGE? _____

DO YOU HAVE ANY SPEECH PROBLEMS? YES NO
IF YES, PLEASE EXPLAIN_____

ARE YOU A MOUTH BREATHER? YES NO
IF YES: WHILE AWAKE? YES NO WHILE ASLEEP? YES NO

HAVE YOU HAD ANY TEETH REMOVED? YES NO
IF YES: WHICH ONES_____AT WHAT AGE_____

HAVE YOU EVER HAD ANY INJURIES TO YOUR FACE, MOUTH, OR TEETH? YES NO
IF YES, WHEN AND WHERE_____

HAVE YOU EVER BEEN INFORMED OF MISSING OR EXTRA TEETH? YES NO
IF YES, PLEASE EXPLAIN_____

HAVE YOU PREVIOUSLY BEEN EVALUATED BY ANOTHER ORTHODONTIST? YES NO

HAVE YOU EVER HAD ORTHODONTIC TREATMENT? YES NO

WHAT ARE YOUR PRIMARY CONCERNS?_____

_____

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____

SIGNATURE DATE