ADULT ORTHODONTIC AQUAINTANCE FORM

Date ___________________

Demographic Information

Name ____ Name you would like to be called _________________________

Age ______ Birth date __________________ Social Security Number ______________________________ Sex (Circle one) F M

Address ____
Street City State Zip Code

Phone Number #1 ____________________ (Work Cell Home) Phone Number #2 ____________________ (Work Cell Home)

Employer ____ Marital Status: Married Single Divorced Other ____________

Physician's Name_______________________________________ Phone # _________________ Date of last exam ________________

Dentist's Name ____ Phone # _________________ Date of last exam ________________

Do you have children in our practice? No Yes, names: ____

Whom may we thank for referring you to us? ____

Please provide your email address for appointment confirmation ____

Health History

YES	NO	
___	___	Do you have any current health problems? Please explain____
___	___	Do you have a history of a major illness? ____
___	___	Have you ever been hospitalized? Please give reason and dates____
___	___	Do you smoke or chew tobacco? ____
___	___	Are you allergic to anything? ____
___	___	Female Patients: Are you pregnant?
___	___	Are you currently taking any medications? Please list: ________________________ ________________________

Please check any of the medical conditions below that you currently have or have been treated for in the past:

___ Abnormal Bleeding/Hemophilia
___ Anemia
___ Arthritis
___ Asthma or Hay Fever
___ Bone Disorders
___ Congenital Heart Defect
___ Diabetes
___ Dizziness
___ Epilepsy
___ Gastrointestinal Disorders
___ Heart Problems
___ Heart Murmur
___ Hepatitis/Liver Disease
___ Herpes
___ High Blood Pressure
___ HIV / Aids
___ Kidney problems
___ Nervous Disorders
___ Pneumonia
___ Prolonged Bleeding
___ Radiation/Chemotherapy
___ Rheumatic Fever
___ Tuberculosis
___ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?______________________________
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Reason for orthodontic consultation? ____

Dental History

YES	NO	
___	___	Did you have braces as a child or teenager? ____
___	___	Has an orthodontist been consulted previously? Name ____
___	___	Have you been informed of any missing or extra permanent teeth? __________________________________
___	___	Have you ever had any injuries to your face, mouth, or teeth? _____________________________________
___	___	Do you have pain with chewing, yawning or wide opening? ____
___	___	Does your jaw make noise and is pain associated with the sounds? _________________________________

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I understand that it is my responsibility to inform this office of any changes in my medical or dental status. I authorize Dr. Christensen, his associates and the dental staff of Durham PDO to perform any necessary dental services that are needed during diagnosis and treatment, including orthodontic records (models, photographs, and radiographs.) I understand that these records may be used for both diagnostic and educational purposes.

Signature ____________________________________ **Relationship to patient** __________________ **Date**______________
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