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 _____

What specific concerns do you have about your teeth? _____

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

Are there any medical conditions we have not discussed that you feel we should be aware of?_____
_____

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**_____