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 if you have been treated for any of the following:

___ ADHD	___ Bleeding/Transfusion	___ Respiratory Problems	___ Speech Problems	___ Other Skin Problems
___ Autism Spectrum	___ Heart Disease	___ Diabetes	___ Vision Problems	___ Canker Sores
___ Anxiety	___ Heart Murmur	___ Gland Problems	___ Cerebral Palsy	___ Cleft Lip/Palate
___ Behavioral Issues	___ Hepatitis A, B or C	___ Growth Issues	___ Epilepsy/Seizures	___ Cold Sores
___ Depression	___ High Blood Pressure	___ Thyroid Disorder	___ Headaches	___ Eating Disorders
___ Learning Differences	___ Rheumatic Fever	___ Bladder/Kidney	___ Neurological Problems	___ Frequent Infections
___ Psychiatric Problems	___ Sickle Cell	___ Liver Disease	___ Muscular Disorder	___ Stomach Problems
___ AIDS	___ Asthma	___ Cancer	___ Joint Problems	___ Ulcer
___ Anemia	___ Cystic Fibrosis	___ Hearing Problems	___ Eczema/Psoriasis	___ Other ___________

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

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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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Consent of Dental Treatment

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 _____ **Date**_____

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Payment Policy

I will be responsible for any charges incurred for orthodontic treatment. I understand that by failing to make payments to Durham Pediatric Dentistry & Orthodontics my account can be turned over to a collection agency. Durham Pediatric Dentistry & Orthodontics will no longer provide dental care 30 days after turn over.

Signature _____ **Date**_____

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Notice of Privacy Practices

I have been provided with Durham Pediatric Dentistry & Orthodontics' **Notice of Privacy Practices** that provides a complete description of their policy on the use and disclosure of protected health information.

Signature _____ **Date**_____
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