

ADULT ORTHODONTIC AQUAINTANCE FORM

Date _____

Demographic Information

Name (Mr., Ms., Mrs, Dr.) _____ 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? _____


~~~~~

YES NO

## Health History

\_\_\_ \_\_\_ 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? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## 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? \_\_\_\_\_
- \_\_\_ \_\_\_ Do you snore or stop breathing during sleep? \_\_\_\_\_

~~~~~

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 _____

~~~~~

## 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 \_\_\_\_\_

~~~~~

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 _____