

## ORTHODONTIC ACQUAINTANCE FROM

### Patient Information (PLEASE PRINT)

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Street Address \_\_\_\_\_ City/State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone# ( ) \_\_\_\_\_ Work Phone # ( ) \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Employers Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Dental Insurance \_\_\_\_\_

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#### Party or Parties Responsible For Payment

\_\_\_\_ Patient \_\_\_\_ Spouse \_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_ Other \_\_\_\_\_

Address if different: \_\_\_\_\_

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Name

Mother/Occupation \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS# \_\_\_\_\_ Dental Insurance \_\_\_\_\_

Employer \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

City/State/Zip \_\_\_\_\_

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Name

Father/occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Dental Insurance \_\_\_\_\_

Employer \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

City/State/Zip \_\_\_\_\_

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Family Dentist \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Family Physician \_\_\_\_\_ Last seen \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

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Who may we thank for referring you to our office? \_\_\_\_\_

\_\_\_\_ Patient \_\_\_\_ Dentist \_\_\_\_ Yellow Pg \_\_\_\_ Insurance \_\_\_\_ Mailing \_\_\_\_ Other

**CHECK IF PATIENT HAD OR NOW HAS:**

☐ Eye pains or problems      ☐ Teeth problems      ☐ Injured or damaged teeth  
☐ Headaches, facial pain      ☐ Jaw problems      ☐ Throat problems  
☐ Mouth problems      ☐ Ear problems, dizziness      ☐ Neck pain or stiffness

**CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:**

Aids	Drug Addiction	Liver Disease
Allergies	Emphysema	Rheumatism
Anemia	Heart Murmur	Rheumatic Fever
Artificial Heart Valve	Heart Pacemaker	Steroid (Cortisone) Medication
Artificial Joint	Heart Surgery	Stroke
Arthritis	Heart Trouble (ANY KIND)	Thyroid Disease
Asthma	Hemodialysis	Tuberculosis
Cancer	Hemophilia	Ulcers
Chemotherapy Treatment	Hepatitis	Venereal Disease
Congestive Heart Failure	Herpes Infections	Vascular Surgery
Congestive Heart Problems	High Blood Pressure	X-Ray or Cobalt Treatment
Diabetes	Kidney Trouble	Yellow Jaundice

1. Are you taking any medication (Drugs) now? ..... Yes No  
If yes please list \_\_\_\_\_

2. Are you allergic to any drugs? ..... Yes No  
If yes please list \_\_\_\_\_

3. Have you ever bleed excessively after a n injury or tooth extraction? ..... Yes No

4. Are you ever short of breathe after mild exertion or chest pain? ..... Yes No

5. Has there been any change in your general health in the last year? ..... Yes No

6. Do you have nasal obstruction? ..... Yes No

7. Have you had dental X-Rays made in the last year? ..... Yes No

8. Have you ever had an injury to your face or jaw? ..... Yes No

9. Have you ever fainted in the dental office? ..... Yes No

10. Do you use tobacco in any form? ..... Yes No  
Chew \_\_\_\_\_ Dip \_\_\_\_\_ Cigarettes \_\_\_\_\_ Cigars \_\_\_\_\_ Pipe \_\_\_\_\_

10. Describe any medical conditions you have that are not on this form: \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_  
(Patient or Guardian for Minor)

Date: \_\_\_\_\_