

ORTHODONTIC ACQUAINTANCE FORM

First Name _____ Last Name _____ Prefer to be called _____
Home Address _____ Apt # _____ City _____ State _____ Zip _____
How long at this address _____ Phone (____) _____ Pager/other phone # (____) _____
Former Address(if less than 3 years) _____ City _____ State _____ Zip _____
Birthdate ____/____/____ Social Security # ____/____/____ Do you have adult orthodontic benefits? No Yes
Employer _____ Position _____ How long _____ Work # (____) _____
Marital Status Single Married Divorced Widowed Separated
Spouse's Name _____ SS# _____ Do they have Adult orthodontic benefits? No Yes
Employer _____ Position _____ How long _____ Work # (____) _____

How did you first hear about our office? _____
Whom may we thank for referring you to our office? _____
When and where are the best times to reach you? _____
Do you anticipate a move or transfer in the near future? No Yes When? _____
Special interests, sports or hobbies: _____

MEDICAL INFORMATION:

Overall medical health Good Fair Poor
Any history of the following: None
 Asthma Blood disease Diabetes
 Hepatitis AIDS/HIV Rheumatic Fever
 Anemia Heart disease Allergies
 Glaucoma Epilepsy Bone Disorders
Any other medical problems we should be aware of?

Is there a tendency to Ear infections Colds Sore throats
Have tonsils and adenoids been removed? No Yes
If so, when? _____
List any drugs or medications being taken

List any allergies or drug sensitivities

Is premedication needed before dental treatment? No Yes

Physician— Dr. _____ Date of last visit _____

DENTAL INFORMATION:

Are you concerned about the appearance of your teeth? No Yes
Are you frightened or anxious about orthodontic treatment? No Yes
What is your main reason for seeing an orthodontist? (check all that apply)
 Crooked teeth Crowding Close spaces Crossbite Overbite Bad bite Hard to chew Can't close mouth
 Jaw pain Headaches Don't like smile Cosmetics Other _____

Have you had previous treatment for TMJ Gum disease
 By Whom? _____

Any previous orthodontic treatment? No Yes
 When? _____

Is this a second opinion? No Yes
 Why? _____
 Who was the first? _____

Have other members of the family had orthodontic treatment?
 If so, whom? _____

Are they satisfied with the end results? No Yes

Do you have any speech problems? No Yes
 Please explain _____

Any injuries to face, head, mouth or teeth? No Yes
 When? _____

Pain in or near ears? No Yes
 When? _____

Clicking or locking of jaws? No Yes
 When? _____

Headaches, facial pain or jaw joint problems? No Yes
 If so, please explain _____

Would you mind wearing braces if necessary? No Yes Invisible braces ? No Yes

What aspect of orthodontic treatment are you most concerned with? Quality Esthetics Cost Discomfort Time

Are you aware of sores, lumps or irritated areas in the mouth? No Yes

Do you have any missing or extra teeth? _____

About your home care:

Please rate your dental health. Good Fair Poor

Do you brush your teeth daily? No Yes

Do you floss your teeth? No Yes

How often? _____

Do you have any history of these habits?

Mouth Breathing Snoring

Thumb sucking Leaning on chin or face

Nail/Lip biting Grinding of teeth

Other _____

General Dentist – Dr. _____ Date of last visit _____

Any other information that would be helpful? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary orthodontic services I may need.

I further authorize that photos taken during treatment may be used in journal articles or promotional materials and are the property of Dr. Shaw and Dr. Ginzler.

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____ Date: _____