ADULT ORTHODONTIC ACQUAINTANCE QUESTIONNAIRE

Patient's Name _____ Name Preferred _____ Sex: Male ___ Female ___
Home Tele# _____ Birthdate _____ Patient's Age _____
Address _____ City _____ State ____ Zip _____
E-mail Address _____

Spouse _____
Your Employer _____ Spouse's Employer _____
Position _____ Position _____
Work Tele# _____ Work Tele# _____

Please complete insurance information on the reverse side. **--->**

Your Family Dentist _____ City _____
How long have you lived in this area? _____
How did you hear about us? _____
What is the purpose of today's visit or your chief concern for treatment? _____
_____

Are there problems with your health now? . . . . . Yes No
Recently, have you been treated by a physician? . . . . . Yes No
Recently, have you taken medication or diet pills? . . . . . Yes No
Have you ever consulted an **orthodontist**? . . . . . Yes No
Have you ever received **orthodontic** treatment? . . . . . Yes No
Have other family members been treated by this practice? . . . . . Yes No
If "Yes" to any above, please explain: _____

Please place an **"X"** if the patient **has ever** had the following:

____ Heart defect, trouble, abnormality
____ Sensitive Gag Reflex
____ Emotional or stress related problems
____ Latex or Nickel Allergy
____ Hepatitis or liver problems
____ Convulsions or seizures
____ Fainting spells
____ Nervous condition
____ Excessive bleeding
____ Gum disease
____ Shoulder or neck pains
____ Soreness in jaws or teeth
____ Popping or noises in jaw joints
____ Ringing or buzzing noise
____ Difficulty opening or closing
____ Locking jaws open or closed
____ Frequent earaches
____ Frequent headaches
____ Frequent ear infections
____ Tongue thrusting
____ Mouthbreathing or noisy sleeping
____ Asthma, allergies or hay fever

The information above is correct and the insurance information is complete.

Patient's Signature _____ Date _____