# ORTHODONTIC ACQUAINTANCE CHART

Date _____ Sex: Male / Female

Patient's Name _____ Birth Date _____ Age _____

Home Address _____ Phone _____

Email Address _____ Referred by _____

Physician _____ Dentist _____

Occupation _____ Employed by _____

Business Address _____ Phone _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ No. of Children _____

Spouse's Name _____ Occupation _____ Employed by _____

Business Address _____ Phone _____

Person financially responsible _____ Relationship _____

Dental Insurance _____ Specify what plan _____

## MEDICAL HISTORY

1. Are you in good health? ..... NO YES
2. Are you now under medical and/or psychological care?

   Please specify _____ NO YES
3. Any history of major illness? If yes, list _____ NO YES
4. Any allergies or drug sensitivity? If yes, list _____ NO YES
5. Taking medication now? if yes, list _____ NO YES
6. Taking medication now or in past for osteoporosis? If yes, list _____ NO YES
7. Please circle any of the following for which you have been treated:

| | | |
|---|---|---|
| Diabetes | Epilepsy | Infectious Hepatitis |
| Arthritis | Tonsillitis | Rheumatic Fever |
| Cancer | Brian Injury | High or Low Blood Pressure |
| Asthma | Tuberculosis | Endocrine Problems |
| Prolonged Bleeding | Heart Trouble | Osteoporosis |
| Nervous Disorders | Hereditary Disorders | Other _____ |

## DENTAL HISTORY

1. Are you in good dental health? ..... NO YES
2. Date of last dental exam? _____
3. Have full mouth x-rays been taken within the last year? ..... NO YES
4. Have tonsils and adenoids been removed? ..... NO YES
5. Have there been any injuries to the face, mouth, or teeth? ..... NO YES
6. Have you ever had oral habits such as lip biting, tongue thrusting, or thumb sucking? ..... NO YES
7. Have you ever had any speech problems? ..... NO YES
8. Have you ever had speech therapy? ..... NO YES
9. Are you a mouth breather while asleep or awake? ..... NO YES
10. Are you aware of any missing or extra permanent teeth? ..... NO YES
11. Have you ever had pain, clicking or popping of the jaw joints? ..... NO YES
12. Do you grind (brux) your teeth? ..... NO YES
13. Has an orthodontist been consulted previously? ..... NO YES
14. Have you or your parents ever had orthodontic treatment? ..... NO YES
15. Are you overly sensitive to dental pain? ..... NO YES
16. List any musical instruments played _____
17. What is your dentist most concerned about? _____
18. What are you most concerned about? _____
19. Other comments _____
20. Person filling form _____