

Orthodontic Treatment for Adults & Adolescents

Adult Orthodontic Acquaintance Card (please print)

Patient's Name ______Date _____

Nickname	Sex	Age	_ Birthdate
Address			_ Yrs at Address
City			
Occupation			
Employed by			
Soc. Sec. No.	☐ Married	☐ Separated ☐	Divorced ☐ Widowed ☐ Single
Spouse's Name			DOB
E-mail			
Patient's Dentist			
Why did you seek this orthodontic consultation?			
Who Referred You?			
Have you ever been examined by an orthodontist before?	□ YES	□ NO	
Is the patient interested in having orthodontic treatment?	□ YES	□ NO	
Has any other family member had orthodontic treatment?	□ YES	□ NO	
Relatives or friends treated here?	□ YES	□ NO	Who?
Does your insurance cover orthodontics?	□ YES	□ NO	
DENTAL INSURAN	ICE INFORI	MATION	
A dental insurance policy is a contract between the insured and and charged directly to the patient's account and the patient or pall fees incurred. For your convenience, we will gladly submit insured policy holder's name	the insurance person respons surance claims	company. Our pro sible for the accou pertaining to any	unt is responsible for payment of
LAST FIRST	MIDDLE		
Policy holder's Date of Birth			
Insurance Co	Group No	Uı	nion Local No
Insurance Co. Address		urance Co. Phon	e
Policy Holder's Employer			
Do you have dual coverage?	3	□ NO	if yes:
Policy holder's name			
Insurance Co	Group No	Uı	nion Local No
Insurance Co. Address	Ins	urance Co. Phon	e
Policy Holder's Employer			

MEDICAL HISTORY

DENTAL HISTORY

Has the patient in good health? Has the patient seen a physician in the last 2 years? Has the patient seen a physician in the last 2 years? What was the reason for the visit? Thumb/finger sucking YES NO DODE thrusting YES NO DODE thrusting YES NO DODE thrusting YES NO DODE thrusting YES NO DODE the patient wear contact lenses? YES NO DODE thrusting YES NO DOD	Physician:					Dentist:			
What was the reason for the visit? Thumbfinger sucking YES NO Unfinished Dental Care YES NO Unfinished Dental Care Thumbfinger sucking YES NO Unfinished Dental Care Thumbfinger sucking YES NO Unstanny drugs or medications now being taken? Mouth breathing YES NO Unstanny allergies or sensitivity? Missing or extra permanent teeth YES NO Unstanny allergies or sensitivity? Missing or extra permanent teeth YES NO Unstanny allergies or sensitivity? Missing or extra permanent teeth YES NO Unstanny allergies or sensitivity? Missing or extra permanent teeth YES NO Unstanny of the following for which the patient has been treated: Have you currently taking biophsphates? YES NO Have you ever been injured by a fall or blow? Diabetes YES NO Have YES NO Have tonsils and adenoids been removed? Have you ever been injured by a fall or blow? Diabetes YES NO Have tonsils and adenoids been removed? YES NO Have tonsils and adenoids been removed? YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO Have any Permanent Any Perman					Date of the last dental exam:				
What was the reason for the visit? Thumbflinger sucking YES NO What was the reason for the visit? Thumbflinger sucking YES NO Tongue thrusting YES NO Teeth grinding/denching YES			in the last	2 years?		Has the patient been told of:			
What was the reason for the visit? Thumbfinger sucking					NO 🗆	Unfinished Dental Care	YES 🗆	NO 🗆	
List any drugs or medications now being taken? Stany drugs or medications now being taken? Tongue thrusting YES NO	What was the reason for	or the visit	12			Thumb/finger sucking	YES 🗆	NO 🗆	
List any drugs or medications now being taken? Mouth breathing	What was the reason is	or the view							
List any allergies or sensitivity?	List and draws or modifie	ations no	w boing to	kon?					
List any allergies or sensitivity? Missing or extra permanent teeth	List any drugs or medic	cations no	w being ta	Ken?					
Does the patient wear contact lenses? YES NO Gum Disease YES NO Are you currently taking blophsphates? YES NO Fear of treatment YES NO Check any of the following for which the patient has been treated: Have you ever been injured by a fall or blow? Diabetes YES NO Have you ever been injured by a fall or blow? Diabetes YES NO Have tonsils and adenoids been removed? Heart Trouble YES NO Have tonsils and adenoids been removed? Heart Trouble YES NO Have tonsils and adenoids been removed? Heart Trouble YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO Have any primary or permanent teeth been extracted? Prolonged Bleeding YES NO YES YES NO YES NO YES NO YES NO YES NO YES YES NO YES YES NO YES									
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Are you currently taking biophsphates? YES NO Fear of treatment YES NO Check any of the following for which the patient has been treated: Have you ever been injured by a fall or blow? YES NO Hepatitis YES NO Have tonsils and adenoids been removed? YES NO Have any primary or permanent teeth been extracted? YES NO Have any primary or permanent teeth been extracted? YES NO YES NO Have any primary or permanent teeth been extracted? YES NO YES NO YES NO Have any primary or permanent teeth been extracted? YES NO					_	Ear infections	YES 🗆	NO 🗆	
Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been treated: Check any of the following for which the patient has been removed: Check any of the following followin	Does the patient wear	contact le	nses?	YES 🗆	NO 🗆	Gum Disease	YES 🗆	NO 🗆	
Have you ever been injured by a fall or blow?	Are you currently taking	g biophsp	hates?	YES 🗆	NO 🗆	Fear of treatment	YES 🗆	NO 🗆	
Diabetes YES NO Have tonsils and adenoids been removed? Heart Trouble YES NO Have tonsils and adenoids been removed? Heart Trouble YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO YES YES	Check any of the follow	ving for wl	nich the pa	tient has be	een				
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Glaucoma YES NO Have any primary or permanent teeth been extracted? High Blood Pressure YES NO YES NO Bone Disorders YES NO YES NO Prolonged Bleeding YES NO Comments: Fainting/Dizziness YES NO Comments: Feliepsy YES N	Heart Trouble					Have torishs and adenoids been remov		/FO D	NO
High Blood Pressure Bone Disorders YES NO YES NO Bone Disorders YES NO Comments: Thyroid Disorders YES NO Comments: Fainting/Dizziness YES NO Comments: Tibuberculosis YES NO Comments: Tibuberculosis YES NO Comments: Fainting/Dizziness YES NO Comments: Tibuberculosis YES NO Comments: Fainting/Dizziness YES NO Comments: Filepsy YES NO Comments:	Glaucoma	YES 🗆	NO 🗆						NO
Bone Disorders YES NO Prolonged Bleeding YES NO Comments: NO Comments: Thyroid Disorders YES NO Comments: Thyroid Disorders YES NO Comments: Tuberculosis YES NO Tuberculo	Rheumatic Fever	YES 🗆	NO 🗆			Have any primary or permanent teeth t	been extr	acted?	
Prolonged Bleeding Thyroid Disorders YES							Y	ES 🗆	NO 🗆
Thyroid Disorders Fainting/Dizziness Fainting/Dizziness Fainting/Dizziness YES									
Fainting/Dizziness YES						Comments:			
Tuberculosis YES NO Epilepsy YES NO Anemia YES NO Asthma YES NO Arthritis YES NO Head & Neck Pain YES NO Immunity Disorders YES NO AIDS YES NO EMERGENCY INFORMATION Name of nearest relative not living with you Relationship Relationship Phone Relationship AUTHORIZATION RELEASE I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.									
Epilepsy YES NO Anemia YES NO Anemia YES NO Arthritis YES Arthritis YE									
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