

ADULT ORTHODONTIC ACQUAINTANCE SHEET

MONTGOMERY PEDIATRIC DENTISTRY P.C.

Date _____ 20_____

Date of Birth _____ Age _____

Patient's Name _____ Name Patient Goes By _____

Home Address _____ Telephone _____

City _____ State _____ Zip _____

Employed By _____ Business Telephone _____

Address if different from patient _____

Spouse's Name _____

Employed By _____ Business Telephone _____

Referred By _____

Patient's Dentist _____ Patient's Physician _____

GENERAL APPRAISAL

What concerns you most about your teeth? _____

Parents or grandparents with similar problem _____

Has any member of your family received orthodontic treatment _____

Date of last dental check-up _____

MEDICAL HISTORY

Are you in good health? _____ Yes No

Do you have any history of major illness? _____ Yes No

No

Check any of the following for which you have been treated:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Liver Involvement |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Allergies |

Does Patient have a tendency to Colds Sore Throats Ear Infections

Have tonsils and adenoids been removed? Yes No What Age? _____

List any drugs or medications now being taken. Give reasons _____

List any allergies or drug sensitivity: _____

DENTAL HISTORY

Have there been any injuries to face, mouth, or teeth? _____ Yes No

Has you ever sucked thumb or fingers? Until what age? _____ Yes No

Do you have any speech problems? _____ Yes No

Are you a mouth breather? While awake? _____ Yes

No

While asleep? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes

No

ACCOUNT RESPONSIBILITIES

Person responsible for Account _____ S.S.# _____

Address if different from patient _____

Employed by _____ Business Telephone _____

Do you have orthodontic Insurance? _____ Yes

No

Group Number _____ Contact Number _____

Initial _____ I authorize this office to obtain a credit report.

Initial _____ I agree to be financially responsible for any and all charges for services rendered by this office. _____

Initial _____ I further understand I am responsible for any collection agency and/or attorney fees, if those services are required to collect

for any services provided by this office.

Responsible Party Signature/ Relation to Patient