beach braces

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Certified Specialist in Orthodontics

Acquaintance Form (ADULT)

Patient's Name: _____ Date: _____

Date of Birth: MM__ / DD_____ / YY_____ Age:_____ Sex: _____ Occupation:_____

Home Address: _____City: _____ Postal Code: _____

Home Tel: _____ Daytime Tel: _____ ☐ Work ☐ Cell ☐ Home

e-mail address (to confirm appointments):_____

Patient's Dentist: _____ Physician: _____ Physician's Tel.:_____

Who may we thank for referring you? _____

Person Responsible for Account: _____ _____

If Person Responsible other than yourself, please indicate relationship:_____

Do you have an insurance plan that covers orthodontic treatment? ☐ Yes ☐ No ☐ Unsure

MEDICAL HISTORY – HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	H.I.V./A.I.D.S.	☐ Yes ☐ No	Kidney Disorder	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Hepatitis A, B, or C	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Sexually Transmitted Diseases	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No	Other: _____	

If you responded YES to any of the above, please give pertinent information: _____

_____

Are you in good health? _____ If you responded 'No' please explain:_____

Do you have any history of major illness and/or operations? _____

List any drugs or medications being taken: Please give reasons: _____

Are you currently taking or have you been given intravenous bisphosphonates (such as Zometa or Aredia) for bone cancer? ☐ Yes ☐ No

Are you currently taking or have you been given oral or intravenous bisphosphonates (such as Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel, or Bonefos) for osteoporosis, osteopenia, or other uses? ☐ Yes ☐ No

List any allergies or drug sensitivities (including sensitivity to metals) _____

Do you have a tendency to colds? ☐ Yes ☐ No Sore Throats? ☐ Yes ☐ No Ear Infections? ☐ Yes ☐ No

Have your tonsils or adenoids been removed? ☐ Yes ☐ No _____ If so, at what age? _____

Women – are you pregnant? ☐ Yes ☐ No

DENTAL HISTORY

Have you ever been treated for a jaw joint problem, including surgery?	☐ Yes ☐ No	Please describe_____
Have you ever had any injuries to the face, mouth or teeth?	☐ Yes ☐ No	Please describe_____
Have you ever sucked your thumb or finger?	☐ Yes ☐ No	Until what age? _____
Do you have any speech problems?	☐ Yes ☐ No	
Do you have frequent canker or cold sores?	☐ Yes ☐ No	
Are you a mouth breather? While Asleep:	☐ Yes ☐ No	While Awake: ☐ Yes ☐ No
Have you been informed of any missing or extra permanent teeth?	☐ Yes ☐ No	
Have you had a previous orthodontic examination?	☐ Yes ☐ No	
Do you want orthodontic treatment?	☐ Yes ☐ No	
Has any other family member had orthodontic treatment?	☐ Yes ☐ No	

Please name the family member if treated in our office: _____

When did you last see your family dentist? _____

Reason for orthodontic consultation: _____

RELEASE OF INFORMATION: I hereby give Dr. J. Daskalogiannakis and/or members of his staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

_____ _____

Signature Date