



THOMAS A. BROWN, D.M.D.
ADULT ORTHODONTIC ACQUAINTANCE SHEET
PATIENT INFORMATION
704-892-3300

Member
American Association of
Orthodontists®



Date _____

Patient's Name _____

What do you prefer
to be called? _____

Address _____

Street

City

State

Zip code

How many years at this address? _____ Previous address? _____

Home Phone _____ Cell _____ Work Phone _____ Employer _____ How Long? _____

Birthdate _____ Age _____ Sex: M F Physician _____ Dentist _____

Patient's Marital Status: Married ___ Separated ___ Divorced ___ Widowed ___ Single ___

IF MARRIED, PLEASE GIVE THE FOLLOWING INFORMATION REGARDING SPOUSE:

Name _____ Employer _____ How long? _____

Work Phone _____ Cell _____ Age _____ Date of Birth _____

Whom may we thank for recommending our office to you? _____

What do you think is your orthodontic problem? _____

Is there anyone else in your family that needs treatment? _____

**RESPONSIBLE PARTY
(If different from yourself)**

Person responsible for your account: (same as above ___) (other ___) Name _____

Address _____

Street

City

State

Zip Code

How many years at this address? _____ Previous address _____

Home Phone _____ Cell/ Work Phone _____ Employer _____ How Long? _____

Birthdate _____ Age _____ Sex: M F

Relationship to patient _____ Married ___ Separated ___ Widowed ___ Single ___

IF MARRIED, PLEASE GIVE FOLLOWING INFORMATION REGARDING SPOUSE:

Name _____ Employer _____ How long? _____

Age _____ Date of Birth _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Relationship _____

Complete Address _____ Phone _____

PATIENT DENTAL HISTORY

Yes No

Have you had any severe head or face injuries? Explain _____

Have you had a history of thumb sucking or finger sucking? Stopped? _____ When? _____

Do you play a musical (wind) instrument? What? _____

Have you consulted an orthodontist previously?

Have you had any previous orthodontic treatment?

Have any family members had orthodontic treatment?

Please check if there is a history of:

Clenching teeth

Jaw joint soreness

Ringing in the ears

Grinding teeth

Jaw joint clicking

Restricted jaw opening

Muscular soreness around head or neck

Jaw joint popping

Jaw locking open or

Headaches (more than normal)

closed

PATIENTS MEDICAL HISTORY

Are you in good health? yes no

Explain: _____

Any major or unusual illness? yes no

Explain: _____

Currently taking medication? yes no

Reason: _____

Currently being treated by a physician? yes no

Reason: _____

Allergies? yes no

List: _____

Drug sensitivity? yes no

List: _____

Have you had or do you have any of the following?:

Yes No

Anemia

Blood Diseases

Prolonged Bleeding

Jaundiced

Rheumatic Fever

Scarlet Fever

Hepatitis

Glaucoma

Are you HIV positive?

Do you have AIDS?

Yes No

Heart problems

Tuberculosis

Diabetes

Endocrine problems

Bone/Joint Disorders

Epilepsy

Herpes

Are you now or ever been addicted to drugs?

Yes No

Frequent colds or flu

Tonsillitis

Adenoiditis

Tonsils removed: Age__

Adenoids removed: Age__

Asthma

Mouth breathing: Awake?_Asleep_

If there are any Yes answers, please explain _____

Is there any other information that may be helpful? _____

Signed: _____ Date: _____

****THIS OFFICE WILL NOT BE RESPONSIBLE FOR PROBLEMS ARISING FROM UNDISCLOSED OR INCORRECT INFORMATION****

Reviewed by _____ Date _____ Updated (date & initials) _____