

ORTHODONTIC ASSOCIATES

Thomas A. Brown, D.M.D., P.A.
704 482 8934

PLEASE COMPLETE
THIS FORM

** ADULT ORTHODONTIC ACQUAINTANCE SHEET **

- PATIENT INFORMATION -

Date _____

Patient's Name _____ What do you prefer to be called? _____

Address _____
 Street City State Zip County

How many years at this address? _____ Previous address _____

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

Birthdate _____ Age _____ Sex: M F Physician _____

Social Security # _____ Driver's License# _____ Family Dentist _____

Marital Status (Please circle): Married Separated Divorced Widowed Single

IF MARRIED, PLEASE GIVE FOLLOWING INFORMATION REGARDING SPOUSE:

Name _____ Employer _____ How Long? _____

Social Security # _____ Driver's License # _____ Work Phone _____

Age: _____ Date of Birth: _____

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

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

- RESPONSIBLE PARTY INFORMATION -

Person responsible for account (same as above ; other give name): _____

Address _____
 Street City State Zip County

How many years at this address? _____ Previous address _____

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

Birthdate _____ Age _____ Sex: M F Social Security # _____ Driver's License# _____

Relationship to Patient _____

Marital Status (Please circle): Married Separated Widowed Single

IF MARRIED, PLEASE GIVE FOLLOWING INFORMATION REGARDING SPOUSE:

Name: _____ Employer _____ How Long? _____

Social Security # _____ Driver's License# _____ Work Phone _____

Age: _____ Date of Birth: _____

- EMERGENCY INFORMATION -

Name of nearest friend or relative not living with you _____ Relationship _____

Complete Address _____ Phone _____

I realize it may be appropriate to obtain a credit report in determining a payment plan.

Signature _____

-PATIENT'S DENTAL HISTORY -

Yes No

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

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

___ ___ Do you play any musical (wind) instruments? _____ 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 and Neck

___ Jaw Joint Popping

___ Jaw Locking Open or Closed

___ Headaches (more than normal)

- PATIENT'S MEDICAL HISTORY -

Are you in good health? ___yes ___no Explain: _____

Any major or unusual illnesses? ___yes ___no Explain: _____

Currently being treated by a physician? ___yes ___no Reason : _____

Currently taking medication? ___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		Yes	No		Yes	No	
___	___	Anemia	___	___	Heart Problems	___	___	Frequent Colds or Flu
___	___	Blood Disease	___	___	Tuberculosis	___	___	Tonsilitis
___	___	Prolonged Bleeding	___	___	Diabetes	___	___	Adenoiditis
___	___	Jaundice	___	___	Endocrine Problems	___	___	Tonsils Removed: Age: _____
___	___	Rheumatic Fever	___	___	Bone/Joint Disorders	___	___	Adenoids Removed: Age: _____
___	___	Scarlet Fever	___	___	Epilepsy	___	___	Asthma
___	___	Hepatitis	___	___	Herpes	___	___	Mouthbreathing: While awake? _____
___	___	Glaucoma						While asleep? _____
___	___	Are you in a high risk group for AIDS?	___	___		___	___	Have you been found to be HIV positive?
___	___	Are you now or ever been addicted to drugs?	___	___		___	___	Do you have AIDS?

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. **

Thank you!!

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