Dr. Joanne E. Collins ORTHODONTIST

Signature

Adult Orthodontic Acquaintance Form

					Date	
Date of Birth: MM	_ DD YY	Age:	Sex: O	ccupation:		
Home Address:				City:	Postal:	
Telephone: Home		B	Business		Cell	
Email:				Dentist:		
Do you have an insurar	nce plan that co	overs orthodontic tr	reatment? □ Yes □ N	No □ Unsure		
Who may we thank for	referring you to	our office?				
MEDICAL HISTOR	Y - HAVF Y	OU BEEN TRE	ATED FOR ANY OF	THE FOLLOW	/ING ?	
Rheumatic Fever	□ Yes □ No	Prolonged		□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No
Heart Murmur	□ Yes □ No	Blood Disc	-	□ Yes □ No	S.T.D.'s	
Mitral Valve Prolapse		Anemia	or doro	□ Yes □ No	Hepatitis A, B, or C	
Heart Disease	□ Yes □ No	Asthma		□ Yes □ No	Liver Disease	Yes 🗆 No
Heart Attack	□ Yes □ No		sis/Respiratory Disease	□ Yes □ No	Kidney Disorder	
Artificial Heart Valve	□ Yes □ No	Diabetes	olori toopii atory Bioodoo	□ Yes □ No	Arthritis	□ Yes □ No
Pace Maker	□ Yes □ No	Glaucoma		□ Yes □ No	Artificial Joints	□ Yes □ No
High Blood Pressure	□ Yes □ No	Thyroid Di		□ Yes □ No	Cancer	□ Yes □ No
Other:	to any of the al	pove questions, ple	ease give pertinent inform	ation:		
If you responded YES Family Physician:				Telephone:		
If you responded YES Family Physician: Are you in good health?	?			Telephone:		
If you responded YES Family Physician: Are you in good health? Do you have any history	?y of major illnes	ss and/or operation		Telephone:		
Family Physician: Are you in good health? Do you have any histor List any drugs or medic	? y of major illnes ations now bei	ss and/or operation	us?	Telephone:		
Family Physician: Are you in good health? Do you have any histor List any drugs or medic	?y of major illnes ations now being sensitivities:	ss and/or operation ng taken: Please g	is?	Telephone:		
If you responded YES Family Physician: Are you in good health? Do you have any history List any drugs or medic List any allergies or dru (Women) Are you pregi	? y of major illnes ations now bei g sensitivities: nant?	ss and/or operation ng taken: Please g	is?	Telephone:		
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Family Physician: Are you in good health? Do you have any histor List any drugs or medic List any allergies or dru (Women) Are you pregi	?	es and/or operation ng taken: Please g	ding surgery?	Telephone:		□ Yes □ No
Family Physician: Are you in good health? Do you have any histor List any drugs or medic List any allergies or dru (Women) Are you pregi	?	es and/or operationing taken: Please g	ding surgery?	Telephone:		□ Yes □ No
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