Dr. Joanne E. Collins
ORTHODONTIST

Adult Orthodontic Acquaintance Form

Name: _____ Date: _____

Date of Birth: MM ____ DD ____ YY ____ Age: _____ Sex: _____ Occupation: _____

Home Address: _____ City: _____ Postal: _____

Telephone: Home _____ Business _____ Cell _____

Email: _____ Dentist: _____

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

Who may we thank for referring you to our office? _____

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

Rheumatic Fever	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No
Heart Murmur	□ Yes □ No	Blood Disorders	□ Yes □ No	S.T.D.'s	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Anemia	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No
Heart Disease	□ Yes □ No	Asthma	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Attack	□ Yes □ No	Tuberculosis/Respiratory Disease	□ Yes □ No	Kidney Disorder	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Diabetes	□ Yes □ No	Arthritis	□ Yes □ No
Pace Maker	□ Yes □ No	Glaucoma	□ Yes □ No	Artificial Joints	□ Yes □ No
High Blood Pressure	□ Yes □ No	Thyroid Disease	□ Yes □ No	Cancer	□ Yes □ No

Other: _____

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

_____

_____

Family Physician: _____ Telephone: _____

Are you in good health? _____

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

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

List any allergies or drug sensitivities: _____

(Women) Are you pregnant? _____

DENTAL HISTORY

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

When did you last see your dentist? _____

Reason for orthodontic consultation: _____

_____

Signature