

MERIDIAN PARK ORTHODONTICS

ADULT ACQUAINTANCE FORM

Last Name _____ First Name _____ Middle Initial _____ Nick Name _____
 BirthDate _____ Age ____ Sex ____ Referred By _____ Dentist (Name & City) _____
 Address _____ City _____ State _____ Zip _____
 HomePhone _____ Physician (Name & City) _____ Hobbies and Interests _____

	PATIENT	SPOUSE
Name		
Date of Birth		
Cell Phone		
Occupation		
Employer/Business Name		
Business Phone		
SSN		
Orthodontic Ins. Co. Name		
Member ID #		
Group #		

Has any member of your family been a patient in this office? Yes No Names _____
 Person responsible for this account _____

MEDICAL HISTORY

Have you been diagnosed or treated for any of the following?

- | | | |
|--|--|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Ear Infections |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent colds and/or flu | <input type="checkbox"/> Adenoids Removed, Age _____ |
| | | <input type="checkbox"/> Tonsils Removed, Age _____ |

List any other illnesses or medical problems _____

List any allergies (including those to any drugs or medications) _____

List any drugs or medications now being taken _____

DENTAL HISTORY

Have you ever sucked a thumb or finger? Until what age? _____

Do you have any speech problems? Any speech therapy? _____

Do you clench or grind your teeth? At night? _____

Do you have pain or clicking upon opening or closing your mouth? _____

Have you had any severe head or face injuries? _____

Have any teeth been injured or chipped due to accidents? _____

Have you been informed of any extra or missing permanent teeth? Which? _____

Is there any noticeable difficulty in chewing or swallowing food? _____

Would you mind wearing braces? _____

Are you aware of any tongue thrusting problems? _____

Facial appearance most resembles Father Mother Neither _____

Has either parent had orthodontic treatment? Which? _____

Have you consulted with another orthodontist? _____

Date of last dental appointment _____ Where x-rays taken? _____

Are you aware that some appointments will infringe upon work/school time? _____

In your own words, what is the problem? _____

What would you like orthodontic treatment to accomplish? _____

Do you have any special concerns about undergoing orthodontic treatment? _____

Patient Signature _____ **Date** _____