Kelly Family ORTHODONTICS

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ADULT ACQUAINTANCE FORM

Date: _____

Patient's Name_____ Nickname_____ Age _____
Date of Birth _____ Sex_____ Phone Number_____ [ ] Cell [ ] Home
Home Address_____ City _____ State_____ Zip _____
Social Security # _____
Patient's Dentist _____ Patient's Physician _____
Whom may we thank for referring you? _____
Married [ ] Single [ ] Divorced [ ] Widowed [ ]

Employer _____ Occupation _____
Business Address _____ E-Mail Address _____
Business Phone _____

Spouse's Name _____ Birth Date _____
Employer & Occupation _____ Phone # _____
Social Security # _____

Names & ages of children in the family _____
Emergency Contact (name & phone number) _____

DENTAL HISTORY

1.	When was your last dental exam?	_____
2.	Have you ever had orthodontic treatment?	Yes [ ] No [ ]
3.	Have you ever had periodontal or gum disease?	Yes [ ] No [ ]
4.	Have you ever been informed of any missing or extra permanent teeth?	Yes [ ] No [ ]
5.	Have you ever been teased about the appearance of your teeth?	Yes [ ] No [ ]
6.	Have you noticed lumps, sores or irritated areas in your mouth?	Yes [ ] No [ ]
7.	Have you ever been treated for problems of your jaw joints?	Yes [ ] No [ ]
8.	Do you have a history of thumb sucking?	Yes [ ] No [ ]
9.	Do you have a history of mouth breathing?	Yes [ ] No [ ]
10.	Do you take antibiotic premedication before any dental procedures?	Yes [ ] No [ ]

What do you wish to gain through orthodontic treatment? _____
Is there any additional information we should know? _____

MEDICAL HEALTH HISTORY

1. Please describe your present health — Excellent [ ] Good [ ] Fair [ ] Poor [ ]
2. Has your health changed in the last year? — Yes [ ] No [ ]
3. Have you ever been hospitalized for illness or surgery? — Yes [ ] No [ ]
4. Has a doctor treated you for any condition in the last two years? — Yes [ ] No [ ]
   Please describe: _____
5. Are you ALLERGIC to any drugs or other substances? — Yes [ ] No [ ]
   Please list: _____
6. Has anyone in your family ever had diabetes? — Yes [ ] No [ ]
7. Is your diet restricted or specially prescribed? — Yes [ ] No [ ]
8. Do you use tobacco products? — Yes [ ] No [ ]
9. Do you have/had a substance abuse problem? — Yes [ ] No [ ]
10. Have you ever taken bisphosphonates for bone disorders or cancer? — Yes [ ] No [ ]
11. Are you taking any medications (aspirin, vitamins, hormones, etc)? — Yes [ ] No [ ]
    If so, please list them with dosages: _____

PLEASE INDICATE YES OR NO FOR EVERY CONDITION, EVEN IF YOU NO LONGER HAVE IT

AIDS/HIV	Yes [ ] No [ ]	Eye Problems	Yes [ ] No [ ]	Nasal Obstructions	Yes [ ] No [ ]
Anemia	Yes [ ] No [ ]	Fainting/Dizziness	Yes [ ] No [ ]	Osteoporosis/Osteopenia	Yes [ ] No [ ]
Anxiety/Depression	Yes [ ] No [ ]	Fever Blisters/Cold Sores	Yes [ ] No [ ]	Psychiatric Care	Yes [ ] No [ ]
Artificial Joints/Valves	Yes [ ] No [ ]	Glaucoma	Yes [ ] No [ ]	Rheumatic Fever	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Hay fever/Allergies	Yes [ ] No [ ]	Scarlet Fever	Yes [ ] No [ ]
Asthma	Yes [ ] No [ ]	Hardenings of Arteries	Yes [ ] No [ ]	Shortness of Breath	Yes [ ] No [ ]
Autism/Asperger's	Yes [ ] No [ ]	Hearing Problems	Yes [ ] No [ ]	Sinus Problems	Yes [ ] No [ ]
Bone Fractures	Yes [ ] No [ ]	Heart Murmurs/Defects	Yes [ ] No [ ]	Speech Disorder/Problems	Yes [ ] No [ ]
Cancer	Yes [ ] No [ ]	Heart Problems	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
Chest Pains	Yes [ ] No [ ]	Hepatitis	Yes [ ] No [ ]	Swollen Glands	Yes [ ] No [ ]
Congenital Heart Lesions	Yes [ ] No [ ]	High/Low Blood Pressure	Yes [ ] No [ ]	Thyroid Problems	Yes [ ] No [ ]
Congenital Heart Defects	Yes [ ] No [ ]	Hives/Rash	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Immune System Problems	Yes [ ] No [ ]	Tumors/Growths	Yes [ ] No [ ]
Eating Disorders	Yes [ ] No [ ]	Infections	Yes [ ] No [ ]	Ulcers	Yes [ ] No [ ]
Emotional Problems	Yes [ ] No [ ]	Jaundice	Yes [ ] No [ ]		
Emphysema	Yes [ ] No [ ]	Kidney Problems	Yes [ ] No [ ]	Other:	
Endocrine Problems	Yes [ ] No [ ]	Liver Problems	Yes [ ] No [ ]		
Epilepsy	Yes [ ] No [ ]	Lung Disease/Problems	Yes [ ] No [ ]		
Excessive Bleeding	Yes [ ] No [ ]	Mumps	Yes [ ] No [ ]		

Please advise us if there are ever any changes, thank you!

Print Name _____ Sign Name _____

Reviewed by _____