

ORTHODONTICS AQUAINTANCE CARD – ADULT

Tom Hartman, DDS, MS

Brian Hartman, DMD

ACCT.# _____

GENERAL INFORMATION

EXAM DATE _____

Patient's Name _____ Age _____ Birthdate _____ Sex _____

Res. Address _____ Zip _____ Phone _____

Mailing Address _____ Zip _____

Marital Status S M D W Who may we thank for referring you to our office? _____

Orthodontic Insurance Yes No

Employer _____ Occupation _____

Bus. Address _____ Phone _____ SSN _____

Spouse's Name _____ Employer _____ Occupation _____

Bus. Address _____ Phone _____ SSN _____

Dentist's Name _____ Physician _____ Oral Surgeon _____

Name and ages of children in family _____

Name and phone of close friend or relative not living with you _____

MEDICAL HISTORY

Are you under the care of a physician? Yes No

Are you in good health? Yes No

Are you taking any medications? _____ Yes No

Are you allergic or sensitive to any medications? _____ Yes No

Have you had your tonsils or adenoids removed? Yes No

Have you ever been exposed to or tested positive to HIV? Yes No

Have you had or do you have any of the following?

(Rheumatic fever, hepatitis, diabetes, asthma, tuberculosis, kidney or liver problems, endocrine condition, epilepsy, stomach ulcers, prolonged bleeding, bone disorder, heart disease.) If so, please circle.

DENTAL HISTORY

Have you had any injury to face, mouth or teeth? Yes No

Do you grind or clench your teeth? Yes No

Do you have any of the following jaw joint symptoms? Yes No

(Pain, joint noise, frequent headaches, difficulty in opening.) If so, please circle.

Have you ever sucked your finger or thumb? Until what age _____ Yes No

Do you have any speech problems? Yes No

Do you breathe mostly through your mouth? Yes No

Please list any musical instruments played _____

ORTHODONTIC HISTORY

Has an orthodontist been consulted previously? Yes No

What motivated you to seek orthodontic care? _____

Has your immediate family received orthodontic services at our office? Yes No

What concerns you the most about the thought of having braces?

(Appearance, cost, how long, discomfort, will it work) Please circle.

Patient's favorite sports, hobbies, interests _____

Patient's Signature _____