CONFIDENTIAL

Get Acquainted Questionnaire

For Adult Patients

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's Full Name ______________________________ Nickname ________________

Age ________ Birthday__________ Sex *Male Female* Height __________ Weight _______

Whom may we thank for referring you to our office? ______________________________

INSURANCE COVERAGE: *Yes No*

Dental Insurance Company____________________

Subscriber______________________________

SS Number ______________________________

Employer________________ DOB_________

Secondary Dental Insurance:____________________

Subscriber ______________________________

SS Number______________________________

Employer__________________ DOB__________

EMERGENCY or ALTERNATE CONTACT (In case we cannot reach you):

Name ______________________________ Relationship to Patient ________________Phone No. ________________

CONTACT INFORMATION:

Patient's Address ____________________ City ______________ Zip ______ Phone No. ______________

Lived There How Long? __________ Anticipate Moving? _____ When and Where? __________________

Family Email address (for contact regarding appointments if necessary) ______________________________

Occupation ______________________________ Employer ______________________________

Business Phone ____________________________ Business Address ______________________________

Spouse's Name (if applicable) ____________________ Spouse's Contact Phone No. ________________

Natural Parents? *Yes No*

Does father have normal teeth? ____________________ Father treated? ______________________________

Does mother have normal teeth? ____________________ Mother treated? ______________________________

Natural Siblings? *Yes No Not applicable*

How many brothers? _____________ Ages _____________ Sisters? _____________ Ages _____________

Do they have any orthodontic problems? ______________ Have they had any orthodontic treatment? ____________

Has anyone in the family or extended family had jaw surgery along with orthodontic treatment? *Yes No*

If yes, please explain ____

Hobbies, Play Musical Instrument, Involved in Athletics, other Avocations? Please list if appliacable________________

____

Signature ____ **Date** ________________

CONFIDENTIAL
DENTAL HISTORY
For Adult Patients

Patient's Last Name ____________________ First ____________________ Middle _________________

Patient's Dentist ____

Dentist's Address ______________________________________ Dentist's Phone Number ___________

1. Yes No dk/u Permanent or "extra" (supernumerary) teeth removed?
2. Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
3. Yes No dk/u Chipped or otherwise injured permanent teeth?
4. Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?
5. Yes No dk/u Jaw fractures, cysts, mouth infections?
6. Yes No dk/u "Dead teeth", root canals treated?
7. Yes No dk/u Bleeding gums, bad taste, mouth odor?
8. Yes No dk/u Periodontal "gum" problems?
9. Yes No dk/u Food impaction between teeth?
10. Yes No dk/u "Gum boils", frequent canker sores, cold sores?
11. Yes No dk/u Thumb, finger, sucking habit? Until ________
12. Yes No dk/u Abnormal swallowing habit (tongue thrusting?)
13. Yes No dk/u Mouth breathing habit, snoring, difficult in breathing?
14. Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
15. Yes No dk/u Any pain in jaw or ringing in the ears?
16. Yes No dk/u Does the patient experience any pain or soreness in the muscles of the face or around the ears?
17. Yes No dk/u Difficulty encountered in chewing or jaw opening?
18. Yes No dk/u Have you ever been treated for "TMJ" problems (your jaw joint and facial muscle pain)?
19. Yes No dk/u Aware of loose, broken, or missing restorations (fillings)?
20. Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
21. Yes No dk/u Concerned about spaced, crooked, protruding teeth?
22. Yes No dk/u Aware or concerned about under or over developed jaw?
23. Yes No dk/u Any relative with similar tooth or jaw relationships?
24. Yes No dk/u Any wisdom tooth problems?
25. Yes No dk/u Has patient ever been advised to take antibiotics prior to dental care?
26. Yes No dk/u Has patient had any serious trouble associated with any previous dental treatment?
27. Yes No dk/u Has patient ever had a prior orthodontic examination or treatment?
28. Yes No dk/u Has patient recently been under another dentist's care? Specialist ____________________________________
    Other ____
29. Yes No dk/u Has patient ever had periodontal (gum) treatment?

Date of most recent examination _______________

How often does patient brush? ___________ floss? ________

What is the patient's (or parents') primary concern? -- Why are you here? ____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following directions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?
____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this dental status I will inform this practice.

_____________________________ ______________________

Signature of parent or guardian Date

4602 Beckley Road, Battle Creek MI 49015 269-963-4118
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CONFIDENTIAL
MEDICAL
For Adult Patients

Patient's Last Name ____________________ First ____________________ Middle ________________

Patient's Physician ____

Physician's Address ________________________________ Physician's Phone Number ___________

1. Yes No dk/u Are you in good health?
2. Yes No dk/u Has there been any change in your health in the last year?
3. Date of last physical exam ______________________________
4. Yes No dk/u Are you now under medical care? If so, for what?
   ____
5. Yes No dk/u Have you ever had a serious illness or operation? If so, please explain ______________________________
   ____
6. Do you have or have you ever had any of the following?
   - a. Yes No dk/u Rheumatic fever or rheumatic heart disease
   - b. Yes No dk/u Congenital heart disease or defect
   - c. Yes No dk/u Cardiovascular disease (heart trouble, heart murmur, heart attack, coronary insufficiency or occlusion, high blood pressure, arteriosclerosis, stroke)
   - d. Yes No dk/u Allergy or hay fever
   - e. Yes No dk/u Asthma
   - f. Yes No dk/u Hives or skin rash
   - g. Yes No dk/u Fainting spells
   - h. Yes No dk/u Diabetes
   - i. Yes No dk/u Hepatitis, jaundice, or liver disease
   - j. Yes No dk/u Inflammatory rheumatism (painfully swollen joints)
   - k. Yes No dk/u Arthritis
   - l. Yes No dk/u Stomach ulcers
   - m. Yes No dk/u Kidney trouble
   - n. Yes No dk/u Tuberculosis
   - o. Yes No dk/u Persistent cough or cough up blood
   - p. Yes No dk/u AIDS or HIV positive
   - q. Yes No dk/u Sexually transmitted disease
   - r. Yes No dk/u Epilepsy or seizure disorder
   - s. Yes No dk/u Artificial joint prosthesis
   - t. Yes No dk/u Substance abuse (alcoholism, drug addiction)
   - u. Yes No dk/u Tobacco use (cigarettes, dip, etc)
   - v. Yes No dk/u Bone metabolism problems or medications to treat bone metabolism problems (osteoporosis, etc.)
7. Yes No dk/u Do you have any chest pain with exercise?
8. Yes No dk/u Are you ever short of breath after mild exercise?
9. Yes No dk/u Do your ankles swell?
10. Yes No dk/u Do you get short of breath when you lie down, or do you require extra pillows to sleep?
11. Yes No dk/u Have you had abnormal bleeding associated with previous surgery?
12. Yes No dk/u Have you ever required a blood transfusion?
13. Yes No dk/u Do you have any blood disorders such as anemia, etc.?
14. Yes No dk/u Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition?
15. Are you taking any of the following?
   - a. Yes No dk/u Antibiotics or sulfa drugs
   - b. Yes No dk/u Anticoagulants (blood thinners)
   - c. Yes No dk/u Medicine for high blood pressure
   - d. Yes No dk/u Cortisone or steroids
   - e. Yes No dk/u Tranquilizers
   - f. Yes No dk/u Aspirin or anti-inflammatory agent
   - g. Yes No dk/u Dilantin or other anti-convulsant
   - h. Yes No dk/u Insulin, Tolbutamide, Orinase, or similar drug
   - i. Yes No dk/u Digitalis or drugs for heart trouble
   - j. Yes No dk/u Nitroglycerin
   - k. Yes No dk/u Narcotic Analgesic
   - l. Yes No dk/u Birth Control "pill"
   - m. Yes No dk/u Alcohol, Antabuse
   - n. Yes No dk/u Recreational Drugs
   - o. Yes No dk/u Bisphosphonates (Actonel, Actonel+Ca, Aredia, Boniva,
   - p. Yes No dk/u Other medications? ___________________ __________
16. ALLERGIES
   - a. Yes No dk/u Local anesthetics (Novocaine, etc.)
   - b. Yes No dk/u Penicillin or other antibiotics
   - c. Yes No dk/u Aspirin or anti-inflammatory drugs
   - d. Yes No dk/u Barbiturates, sedatives, or sleeping pills
   - e. Yes No dk/u Narcotic analgesics
   - f. Any other?______________________________________ __________

WOMEN ONLY

17. Yes No dk/u Are you pregnant or trying to become pregnant?

If there are any changes later to this history records or medical status, I will info
not hold my orthodontist or any member of his/her staff responsible for any erro

____

Signature of parent or guardian Date

Medical History Update or Changes: Date: Comments: Initials:

____