



Adult Orthodontic Acquaintance Form

Certified Specialists in Orthodontics – Dr. Norm Riekenbrauck, Dr. Steven Ma & Dr. Greg Hergott

Patients Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: M / F Occupation: _____

Home Address: _____

Home Number: _____ Daytime Number: _____ Email: _____

Patient's Dentist: _____

Physician: _____ Physician's Number: _____

Who may we thank for referring you? _____

Person Responsible for account if other than yourself: _____ Relationship: _____

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

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

Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type 1 Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	H.I.V./A.I.D.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone/Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____					

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

Are you in good health? Yes No If you responded 'No', please explain: _____

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

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

List any allergies or drug sensitivities: _____

Have you had your tonsils or adenoids removed: Yes No At what age: _____

Do you have a tendency for colds? Yes No Sore throats? Yes No Ear Infections? Yes No

(Women) Are you pregnant? Yes No

DENTAL HISTORY

Have you ever been treated for jaw joint problem, including surgery? Yes No

Have there been any injuries to the face, mouth or teeth? Yes No Please describe: _____

Do you have any speech problems? Yes No

Do you have frequent cankers or cold sores? Yes No

Are you a mouth breather? While asleep? Yes No While awake? _____

Have you ever been informed of any missing or extra permanent teeth? Yes No

Have you ever had a previous orthodontic evaluation? Yes No

Do you want orthodontic treatment? Yes No

Has any other family member had braces or orthodontic treatment? Yes No

Please name the family member if treated in our office: _____

When did you last see your dentist? _____

Reason for orthodontic consultation: _____

Type of work and hobbies: _____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

Signature

Date