



GET ACQUAINTED QUESTIONNAIRE - ADULT

The following information is needed to enable us to give you the most consideration and best services possible. Please have **ALL** sides of the form filled out **BEFORE** your appointment. This information is of course confidential. Thank you.

Patient's Full Name _____ **Preferred Name** _____

Social Security Number _____ **Sex: M/F** _____ **Age:** _____ **Birthdate:** _____

Home Address _____ **City** _____ **Zip Code** _____

Cell Phone # () _____ **Height: ft** _____ **in** _____ **Weight** _____ **lbs**

Occupation _____ **Employer** _____ **# YRS Employed** _____

Business Ph # _____ **Email address** _____

Hobbies _____

Patient's Dentist _____ **Phone # ()** _____

Date of last cleaning and check-up _____

Had unfavorable reaction to dental care? _____

What is your primary concern _____

What are your feelings about braces? _____

Have you ever been seen by an orthodontist? _____

How many children do you have? _____ **Ages** _____

How many sisters do you have? _____ **Their Age** _____

Do they have any orthodontic problems? _____

Have they had any orthodontic treatment? _____

Name(s) of family member(s) treated in our practice _____

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

FAMILY INFORMATION

Spouse's name _____ **Phone #** _____



Occupation _____ **# YRS Employed** _____

Employer _____ **Business ph # (_____)** _____

Social Security # _____ **Cell Phone # (_____)** _____

Email address _____

HEALTH INFORMATION

- | | | |
|--|---|---|
| <input type="checkbox"/> Any Heart Disease | <input type="checkbox"/> Is Patient Under Medical Care | <input type="checkbox"/> Any Nervous/Emotional Problems |
| <input type="checkbox"/> Any Respiratory | <input type="checkbox"/> Anemia | <input type="checkbox"/> Does the patient smoke |
| <input type="checkbox"/> Any Blood Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Any drug addiction |
| <input type="checkbox"/> Any Broken Bones | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Is the patient pregnant at this time |
| <input type="checkbox"/> Any Thyroid Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Any Kidney/Liver Disease | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> H.I.V Positive | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Any Venereal Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Any Intestinal Disease | <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Measles/Mumps/Chicken Pox |
| <input type="checkbox"/> Any Bone Disease | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Is the patient in good health |
| <input type="checkbox"/> Allergic to Anything | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Any High/Low blood pressure |
| <input type="checkbox"/> Any Endocrine Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Has the patient reached puberty |
| <input type="checkbox"/> Any Prolonged Bleeding | <input type="checkbox"/> Asthma or Hay Fever | |
| <input type="checkbox"/> Had a Physical this year | <input type="checkbox"/> Rheumatism/ Arthritis | |
| <input type="checkbox"/> Rheumatic/Yellow/Scarlet Fever | <input type="checkbox"/> Any Tumors or Cancer | |
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome | <input type="checkbox"/> Any History of Fainting or Dizziness | |

Medications taken _____

DENTAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Has the patient seen a general dentist in the last year | <input type="checkbox"/> Does the patient have or ever had any of the following habits |
| <input type="checkbox"/> Any pain, clicking or discomfort in or near the ears | <input type="checkbox"/> Cheek/tongue or lip chewing |
| <input type="checkbox"/> Has the mouth face or teeth been injured by a fall or accident | <input type="checkbox"/> Thumb sucking |
| <input type="checkbox"/> Have you been informed of missing or extra permanent teeth | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Are you aware of any gum problems | <input type="checkbox"/> Finger nail biting |
| <input type="checkbox"/> Have patients tonsils or adenoids been removed | <input type="checkbox"/> Clenching teeth |
| <input type="checkbox"/> Do you feel the patient can benefit from orthodontic treatment | <input type="checkbox"/> Tongue thrusting |
| <input type="checkbox"/> Is the patient happy with their SMILE | <input type="checkbox"/> Grind Teeth |
| <input type="checkbox"/> Does the patient want to improve their SMILE | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Would the patient mind wearing BRACES | |

Date _____ Signature _____