

**GET ACQUAINTED QUESTIONNAIRE  
ADULT**

*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 \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Family Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit: \_\_\_\_\_  
 Family Physician \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  
 Name patient likes to be called \_\_\_\_\_  
 Sports, Hobbies, etc. \_\_\_\_\_  
 Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
 Children (names/ages) \_\_\_\_\_  
 Major reason for seeking orthodontic treatment \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_

**DENTAL HISTORY**

	No	Unsure	Yes	
Have there been any injuries to the face, mouth or teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Are you aware of any missing or extra permanent teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Do you have any speech problems or concerns? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Are you especially apprehensive toward dental visits? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
<b>Do you:</b>				
• clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• brush your teeth conscientiously? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
<b>Do you have:</b>				
• a history of periodontal (gum) problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• a problem with frequent cold/canker sores? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any difficulty opening your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any clicking or discomfort in jaw joints near ears? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• headaches or neckaches regularly? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• pain in the jaw joints while eating? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any congenital abnormalities? (cleft palate, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____

**ATTITUDE TOWARD TREATMENT**

Are you aware of spaced, crooked or protruding teeth?.....  No....  Yes    Concerned?.....  No...  Yes  
 Do you feel that it is becoming .....  Better.....  Worse.....  Staying the Same  
 What would you most like to have orthodontic treatment accomplish? \_\_\_\_\_  
 Are you aware that some appointments will infringe upon school/work time?.....  No.....  Yes  
 Have you had any previous orthodontic examinations?.....  No.....  Yes.... Doctor: \_\_\_\_\_ Date: \_\_\_\_\_  
 Have you had any previous orthodontic treatment? \_\_\_\_\_ Describe: \_\_\_\_\_

**PLEASE COMPLETE REVERSE SIDE**

## MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	_____	_____	_____	Hay Fever	_____	_____	_____
Allergies	_____	_____	_____	Healing Disorder	_____	_____	_____
Anemia or Bleeding Problems	_____	_____	_____	Headaches	_____	_____	_____
Arthritis	_____	_____	_____	Hearing Disorder	_____	_____	_____
Asthma	_____	_____	_____	Heart Disorders (murmur, etc.)	_____	_____	_____
Behavioral Problems	_____	_____	_____	Hepatitis or Liver Disorders	_____	_____	_____
Bone or Joint Disorder	_____	_____	_____	HIV Positive	_____	_____	_____
Breathing or Nasal Disorder	_____	_____	_____	Kidney or Bladder Condition	_____	_____	_____
Diabetes	_____	_____	_____	Mononucleosis	_____	_____	_____
Earaches	_____	_____	_____	Nervous Disorders	_____	_____	_____
Epilepsy or Convulsions	_____	_____	_____	Psychiatric Treatment	_____	_____	_____
Fainting or Dizziness	_____	_____	_____	Psychological Disorder	_____	_____	_____
Gagging or Nausea Problems	_____	_____	_____	Rheumatic Fever	_____	_____	_____
Growth or Endocrine Condition	_____	_____	_____	Venereal Disease	_____	_____	_____

General health: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Birth Defects \_\_\_\_\_

Presently under medical care for \_\_\_\_\_

Drugs or medication being taken now (drug and dose) \_\_\_\_\_

Allergic to any medication \_\_\_\_\_

Do you require antibiotic premedication prior to dental appointments?.....  No....  Yes

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

Have tonsils and adenoids been removed?....  No.....  Yes..... At what age? \_\_\_\_\_

Do you snore at night?.....  No.....  Yes

### RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_

Residence \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Spouse's Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency contact person \_\_\_\_\_

Name

Home Phone

Work Phone

### ORTHODONTIC INSURANCE INFORMATION

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Do you have dual coverage?  No  Yes If Yes:

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_

I give permission for x-rays and photographs to be used for research/educational purposes \_\_\_\_\_

Initials