



millerorthodontics

ADULT ACQUAINTANCE FORM

DATE: _____

PATIENT INFORMATION	Name	Preferred Name	
	Date of Birth	Age	Gender: Male Female
	Social Security Number	Email	
	Employer	Occupation	
	Home Address	City	State
	Mailing Address	City	State
	Home Phone	Work Phone	
	Whom may we thank for referring you?	Cell Phone	
	General Dentist	Date of Last Visit	

FAMILY INFORMATION	Spouse's Name	Date of Birth
	Social Security Number	
	Work Phone	Cell Phone
	Employer	Occupation
	Children's Names & Ages	
	Have we treated any of your family members in this office?	
	If yes, please list their name(s)	

FINANCIAL & INSURANCE INFORMATION	Person Financially Responsible	
	Relationship to Patient	
	Are you covered by orthodontic insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please complete the following:	
	Insurance Company Name	Group Number
	Policy Number	Where does the insured work?
	Names of Insured	Social Security Number
	Date of Birth	
	Is there a secondary insurance policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please provide details	

AGREEMENT	This office reserves the right to verify credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agency.	
	Signature	Date

(please complete remainder of form on reverse)

MEDICAL HISTORY	Physician		
	Have you ever had any of the following? (if yes, please check the box)		
	<input type="checkbox"/> Allergies to Latex / Metal	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> AIDS/HIV
	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> Allergy to Dental Anesthetic	<input type="checkbox"/> Allergy to Plastics
	<input type="checkbox"/> Anemia/Radiation Treatment	<input type="checkbox"/> Artificial Bone/Joints/Valves	<input type="checkbox"/> Asthma
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cancer/Lukemia	<input type="checkbox"/> Cerebral Palsy
	<input type="checkbox"/> Congenital Heart Defects/Pacemaker	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Abuse
	<input type="checkbox"/> Fever Blisters/Herpes	<input type="checkbox"/> Handicaps/Disabilities	<input type="checkbox"/> Hearing Impairment
	<input type="checkbox"/> Heart Attack/Problems	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Murmur
	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hepatitis (circle A B C)	<input type="checkbox"/> High/Low Blood Pressure
	<input type="checkbox"/> Kidney/Liver Problems	<input type="checkbox"/> Measles/Mumps	<input type="checkbox"/> Mitral Valve Prolapse
	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Rhemumatic/Scarlet Fever
	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tuberculosis

MEDICAL INFORMATION	Do you require antibiotic premedication for dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Are you currently pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Please discuss any medical problems that you have had.
	Please list all medications and reasons for each.

DENTAL HISTORY	Do you like your smile? Yes <input type="checkbox"/> No <input type="checkbox"/>
	What concerns you most about your teeth?
	Have you ever been evaluated for orthodontic treatment before? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, was treatment done? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Doctor's Name _____ Date Seen _____
	Have there been any injuries to the face, mouth or chin? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you been informed of any extra or missing permanent teeth? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Have you ever been told you had or been treated for periodontal (gum) problems? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Your current dental health is _____ Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>
	Do you generally breathe through your mouth? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, please circle _____ While awake _____ While Asleep
	Do you smoke or use tobacco in any form? Yes <input type="checkbox"/> No <input type="checkbox"/>

OFFICE USE ONLY	Chief Complaint
	Initials _____ Date _____
	I verbally reviewed the medical/dental information above with the patient named herein.
	Doctor's Comments