OFFICE PREFERENCE _____

Cole Orthodontic Associates, P.C.

ADULT ORTHODONTIC ACQUAINTANCE FORM

GENERAL INFORMATION

DATE _____ DATE OF BIRTH _____
AGE _____ SEX _____

1. YOUR NAME _____ E-MAIL _____
2. RESIDENTIAL ADDRESS _____ ZIP _____ YEARS AT CURRENT ADDRESS _____
3. HOME PHONE NUMBER _____ DAYTIME PHONE NUMBER _____
4. LAST SCHOOL ATTENDED _____ REFERRED BY: _____
5. DENTIST'S NAME _____ ORAL SURGEON'S NAME _____
6. MARITAL STATUS: SINGLE ☐ MARRIED ☐ REMARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐
7. YOUR OCCUPATION _____ YEARS WITH CURRENT EMPLOYER _____
8. EMPLOYED BY _____ BUSINESS TELEPHONE _____
9. BUSINESS ADDRESS _____
10. SPOUSE'S NAME _____ OCCUPATION _____ YEARS WITH CURRENT EMPLOYER _____
11. EMPLOYED BY _____ BUSINESS TELEPHONE _____
12. BUSINESS ADDRESS _____
13. NAMES AND AGES OF YOUR CHILDREN _____
14. ORTHODONTIC INSURANCE COMPANY _____
    GROUP NUMBER _____ POLICY NUMBER/SOCIAL SECURITY # _____
15. FINANCIAL RESPONSIBILITY: SELF ☐ SPOUSE ☐ OTHER ☐
16. CREDIT REFERENCE: BANK _____ OTHER: _____
    SS # _____ BIRTHDATE _____
17. MOST CONVENIENT APPOINTMENT TIME: TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY ☐
    MORNING ☐ AFTERNOON ☐
18. PATIENT INTERESTS: _____
19. CLOSEST RELATIVE OR FRIEND: NAME _____ PHONE NO. _____
20. ADDITIONAL INFORMATION: _____

MEDICAL HEALTH

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE DATE, TREATING DOCTOR, TREATMENT REQUIRED, AND CURRENT STATUS ON THE REVERSE SIDE (UNDER NO. 98) AND INDICATE THE NUMBER OF THE QUESTION YOU ARE ELABORATING UPON. ALSO PLEASE INDICATE WITH AN * ANY CONDITIONS WHICH SIBLINGS OR PARENTS POSSESS.

21. GENERAL HEALTH: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐
22. NAME AND ADDRESS OF PHYSICIAN _____
23. LAST COMPLETED PHYSICAL _____ HAVE YOU EVER BEEN UNDER TREATMENT IN A HOSPITAL?
24. YES ☐ NO ☐ REASON: _____
25. ARE YOU TAKING ANY MEDICATION NOW? YES ☐ NO ☐ NAME(S) AND PURPOSE(S) _____

HAVE YOU EVER HAD OR DO YOU HAVE:

26. A BLOOD TRANSFUSION	YES ☐	NO ☐	27. MONONUCLEOSIS	YES ☐	NO ☐
28. HEART DISEASE	YES ☐	NO ☐	29. RHEUMATIC FEVER	YES ☐	NO ☐
30. ABNORMAL BLOOD PRESSURE	YES ☐	NO ☐	31. ULCERS	YES ☐	NO ☐
32. TUBERCULOSIS OR LUNG DISEASE	YES ☐	NO ☐	33. DIABETES	YES ☐	NO ☐
34. EPILEPSY/CONVULSIONS	YES ☐	NO ☐	35. ANEMIA	YES ☐	NO ☐
36. STOMACH/INTESTINAL PROBLEMS	YES ☐	NO ☐	37. CONGENITAL HEART LESIONS	YES ☐	NO ☐
38. GLAUCOMA	YES ☐	NO ☐	39. ARTHRITIS	YES ☐	NO ☐
40. CONTACT LENSES	YES ☐	NO ☐	41. MUSCLE PROBLEMS	YES ☐	NO ☐
42. CONNECTIVE TISSUE DISEASE	YES ☐	NO ☐	43. FREQUENT COLDS	YES ☐	NO ☐
44. FREQUENT EAR INFECTIONS	YES ☐	NO ☐	45. FREQUENT SORE THROAT	YES ☐	NO ☐
46. IMMUNE SYSTEM DISORDER	YES ☐	NO ☐	47. NERVOUS SYSTEM DISORDER	YES ☐	NO ☐
48. EMOTIONAL/ PSYCHOLOGICAL PROBLEMS	YES ☐	NO ☐	49. HEART MURMUR	YES ☐	NO ☐
50. JAUNDICE	YES ☐	NO ☐	51. ASTHMA OR HAY FEVER	YES ☐	NO ☐
52. SINUS TROUBLE	YES ☐	NO ☐	53. AIDS VIRUS OR ARC	YES ☐	NO ☐
54. HEPATITIS/LIVER DISEASE	YES ☐	NO ☐	55. STROKE	YES ☐	NO ☐
56. PERSISTENT COUGH	YES ☐	NO ☐	57. SKELETAL/BONE DISORDERS	YES ☐	NO ☐

↓ CONTINUED ON BACK ↓

58. SEXUALLY TRANSMITTED DISEASE.....YES ☐ NO ☐ 59. CANCER.....YES ☐ NO ☐
60. PROLONGED BLEEDING .....YES ☐ NO ☐ 61. EXCESSIVE URINATION OR THIRST.....YES ☐ NO ☐
62. COMPLICATION FOLLOWING MEDICAL TX.. YES ☐ NO ☐ 63. AN INTRAVENOUS DRUG HABIT.....YES ☐ NO ☐

WOMEN
64. ARE YOU PREGNANT? .....YES ☐ NO ☐ 65. ARE YOU PAST MENOPAUSE?.....YES ☐ NO ☐

HAVE YOU EVER HAD OR DO YOU HAVE:
66. A NEED FOR ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL TREATMENT? .....YES ☐ NO ☐
67. A HABIT OF BREATHING THROUGH YOUR MOUTH? WHILE AWAKE? YES ☐ NO ☐ WHILE ASLEEP? YES ☐ NO ☐
68. ANY ALLERGIES OR DRUG SENSITIVITIES? YES ☐ NO ☐ _____

_____

DENTAL HEALTH

69. REASON FOR TODAY'S VISIT: _____
70. WHEN WAS YOUR LAST DENTAL VISIT? _____
71. HAVE YOU EVER HAD ANY PROBLEM ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES ☐ NO ☐
    IF SO, EXPLAIN: _____
72. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____
73. WHAT MOUTH RINSE (IF ANY) DO YOU USE? _____
74. WHAT TEXTURE BRUSH DO YOU USE? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐
75. HOW OFTEN DO YOU FLOSS? _____
76. DO YOUR GUMS BLEED WHILE BRUSHING YES ☐ NO ☐ WHILE FLOSSING? YES ☐ NO ☐
77. DO YOU FEEL TWINGES OF PAIN WHEN YOUR TEETH COME IN CONTACT WITH:
    A. HOT FOODS OR LIQUIDS, I.E. SOUP, COFFEE, TEA, ETC. ..... YES ☐ NO ☐
    B. COLD FOODS OR LIQUIDS, I.E. ICE CREAM, COLD FRUIT, ETC. ..... YES ☐ NO ☐
78. DO YOU FEEL PAIN TO ANY OF YOUR TEETH WHEN BRUSHING OR FLOSSING THEM?..... YES ☐ NO ☐
79. DO YOU HAVE ANY EXTRA <u>PERMANENT</u> TEETH? ..... YES ☐ NO ☐
80. DO YOUR GUMS FEEL TENDER OR SWOLLEN? ..... YES ☐ NO ☐
81. DO YOU HAVE DIFFICULTY CHEWING? ..... YES ☐ NO ☐
82. DO YOU CLENCH OR GRIND YOUR JAWS WHILE SLEEPING OR DURING THE DAY? ..... YES ☐ NO ☐
    OTHER HABITS, I.E., NAIL BITING, PENCIL CHEWING, ETC. ..... YES ☐ NO ☐
83. DO YOU HAVE A PROBLEM WITH HEADACHES?..... YES ☐ NO ☐
84. DO YOUR JAWS EVER FEEL TIRED?..... YES ☐ NO ☐
85. HAVE YOU EVER HAD CLICKING OR PAIN IN JAW?..... YES ☐ NO ☐
86. DO YOU SMOKE OR CHEW TOBACCO?..... YES ☐ NO ☐
87. DO YOU DRINK ALCOHOL? YES ☐ NO ☐ NUMBER OF DRINKS A DAY _____
88. DO YOU USE RECREATIONAL DRUGS?..... YES ☐ NO ☐
89. DO YOU USUALLY HAVE MANY CAVITIES?..... YES ☐ NO ☐
90. HAVE YOU EVER CHIPPED ANY TEETH?..... YES ☐ NO ☐
91. DO YOU LOSE OR BREAK FILLINGS?..... YES ☐ NO ☐
92. HAVE YOU EVER HAD ANY INJURIES TO THE HEAD, FACE, JAWS, MOUTH, OR TEETH? ..... YES ☐ NO ☐
93. DO YOU GAG EASILY?..... YES ☐ NO ☐
94. ARE YOU FAMILIAR WITH THE TERM "PREVENTIVE DENTISTRY"?..... YES ☐ NO ☐
95. IS THERE ANY PROBLEM WITH TOOTH POSITION(S), JAW POSITION, OR BITE?..... YES ☐ NO ☐
    IF SO, EXPLAIN: _____
96. DO YOU FEEL SELF-CONSCIOUS ABOUT YOUR TEETH OR APPEARANCE?..... YES ☐ NO ☐
97. HAVE YOU EVER CONSULTED AN ORTHODONTIST PREVIOUSLY?..... YES ☐ NO ☐
98. HAVE YOU EVER HAD ORTHODONTIC TREATMENT?..... YES ☐ NO ☐
99. PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT:

_____
PATIENT'S SIGNATURE DATE