Cole Orthodontic Associates, P.C.

YOUNG ADULT/ADOLESCENT ORTHODONTIC ACQUAINTANCE FORM

DATE ______________________ 20________

GENERAL INFORMATION

DATE OF BIRTH ______________________

1. PATIENT'S NAME ______________________ AGE __________ SEX __________
2. RESIDENTIAL ADDRESS ______________________ ZIP __________
3. HOME PHONE NUMBER ______________________ PARENT/GUARDIAN'S DAYTIME PHONE NUMBER ______________________
4. SCHOOL ______________________ REFERRED BY: ______________________
5. DENTIST'S NAME ______________________ ORAL SURGEON'S NAME ______________________
6. NAME OF ACCOMPANYING ADULT ______________________ RELATIONSHIP TO PATIENT ______________________
7. FATHER'S NAME ______________________ OCCUPATION ______________________
8. EMPLOYED BY ______________________ BUSINESS TELEPHONE ______________________
9. BUSINESS ADDRESS ______________________
10. MOTHER'S NAME ______________________ OCCUPATION ______________________
11. EMPLOYED BY ______________________ BUSINESS TELEPHONE ______________________
12. BUSINESS ADDRESS ______________________
13. LEGAL GUARDIAN ______________________ MARITAL STATUS: Married ☐ Divorced ☐ Separated ☐ Other ☐
    ADDRESS AND PHONE NUMBER ______________________
14. ORTHODONTIC INSURANCE COMPANY ______________________
    GROUP NUMBER ______________________ POLICY NUMBER/SOCIAL SECURITY # ______________________
15. WHO ASSUMES FINANCIAL RESPONSIBILITY? ______________________
16. CREDIT REFERENCE: BANK ______________________ OTHER: ______________________
    SS # OF RESPONSIBLE PARTY ______________________ YEARS AT PRESENT ADDRESS: ______ BIRTHDATE __________
    OCCUPATION ______________________ YEARS WITH PRESENT EMPLOYER: __________
17. MOST CONVENIENT APPOINTMENT TIME: MON. ☐ TUES. ☐ WED. ☐ THURS. ☐ FRI. ☐ A.M. ☐ P.M. ☐
18. NAME(S) AND AGE(S) OF OTHER CHILDREN IN FAMILY: ______________________
19. PATIENT'S INTERESTS: ______________________
20. CLOSEST RELATIVE OR FRIEND: NAME ______________________ PHONE NO. ______________________

MEDICAL HEALTH This section to be completed by the patient with parental input:

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. 99) 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) ______________________

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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. ANEMA .... YES ☐ NO ☐
36. STOMACH/INTESTINGAL PROBLEM .... 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 ↓

HAVE YOU EVER HAD OR DO YOU HAVE:

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 ☐ ____________________

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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 ANY PAIN TO ANY OF YOUR TEETH WHEN BRUSHING OR FLOSSING THEM? .... YES ☐ NO ☐
79. DO YOU HAVE ANY EXTRA **PERMANENT** TEETH OR MISSING **PERMANENT** 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. ____________________
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 PER 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 POSITIONS(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: ____________________

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PARENT'S SIGNATURE DATE

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PATIENT'S SIGNATURE DATE