nu smile ORTHODONTICS

# ORTHODONTIC ACQUAINTANCE CARD

*ADULT*

TODAY'S DATE: _____/_____/_____
DAY MONTH YEAR

Patient Name (Last): _____ (First): _____ Date of Birth (D/M/Y):_____

Address: _____ City: _____ Postal Code: _____

Phone (s): _____Email: _____

Employer Name: _____

Dental Insurance carrier(s) name: _____

Policy #: _____ ID #: _____ Policy # _____ ID #: _____

Dentist: _____ Physician: _____

Who may we thank for referring you to our office: ☐ Dentist ☐ Family/Friend ☐ Patient ☐ Google ☐ Facebook ☐Other

Details:_____

Reason for seeking an orthodontic exam/tell us what you do not like about your teeth:

_____

## MEDICAL HISTORY

**Please indicate if you have ever been treated for:**

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Hormone problem | ☐ Tonsils/adenoids | ☐ Skin problems |
| ☐ Heart murmur | ☐ Diabetes | ☐ Sleep apnea/snoring | ☐ Cold sores |
| ☐ Heart Disease | ☐ Tuberculosis | ☐ Seizures | ☐ Osteoporosis |
| ☐ Clenching/grinding | ☐ Cancer | ☐ Asthma | ☐ Growth problems |
| ☐ Anemia | ☐ Hepatitis | ☐ Cleft lip/palate | ☐ Immune disorders |

Details:

_____

| | | | |
|---|---|---|---|
| Do you have any health problems? | ☐ Yes | ☐ No | If no, Explain: _____ |
| Do you have any history of major illness? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Are you taking any drugs or medication? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Do you have any allergies? | ☐ Yes | ☐ No | If yes, Explain: _____ |

## DENTAL HISTORY

| | | | |
|---|---|---|---|
| Have you ever had any serious head or face injuries? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Have you ever sucked a thumb or finger? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Are you a mouth breather? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Was your last dental check-up within 6 months? | ☐ Yes | ☐ No | If yes, Explain: _____ |
| Have you had an orthodontic consultation before? | ☐ Yes | ☐ No | If yes, When/Who? _____ |
| Have you had previous orthodontic treatment? | ☐ Yes | ☐ No | If yes, When/Who? _____ |