Foster Orthodontics — *Practice Limited to Orthodontics*

Orthodontic (ADULT) Acquaintance Card

Patient Information

Date _____

Patient's Name_____ Preferred Name_____ Sex___ DOB_____

Home Address_____ City_____

State___ Zip_____ Home #/Cell_____ Age ____ Referred by _____

Employer_____ Work #_____

Patients Dentist_____ Patients Physician_____

Spouse's Name_____ Employer_____

Address (if different) _____ Social Security #_____ Cell/work_____

Previous Address if less than 2 years_____

General Appraisal

Why did you make this appointment?_____

What is your concern about your teeth? Appearance____ Function____ Psychological ____Emotional____ Other____

Have any members of your family received orthodontic treatment? _____Who _____When_____ Doctor_____

Have you been evaluated or treated by another orthodontist? Yes____ No____ By Whom_____

Are you aware that some appointments will infringe on time at work? Yes____ No____

Hobbies, Activities, Special interests_____

Medical History

Are you in good health? Yes____No____Explain_____

Do you have any history of major illness? Yes____No____Explain_____

Have your tonsils and adenoids been removed? Yes___ No____ Age____ List any drug allergies_____

List any medications currently taking and reason_____

Dental History

Have there been any injuries to the face, mouth or teeth? Yes____ No____ Explain_____

Have you been informed of any missing or extra permanent teeth? Yes___ No___ Explain_____

Do you or have you had any speech problems? Yes___ No___

Are you a mouth breather? Yes___ No___ While awake? Yes ___ No___ While Asleep? Yes___ No___

Do you notice difficulty in chewing or swallowing food? Yes___ No___ How long since last visit to dentist?_____

Do you have orthodontic insurance? Yes____ No____

_____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT