

YORK MILLS ORTHODONTICS

Adult Orthodontic Acquaintance Form

Name: _____ Date: _____

Date of Birth: M/D/Y _____ Age: _____ Sex: _____

Home Address: _____ City: _____ Postal Code: _____ Tel: _____

Work Address: _____ City: _____ Postal Code: _____ Tel: _____

Patient's Dentist: _____ Tel: _____ Family Physician: _____ Tel: _____

Who may we thank for referring you? _____

Person Responsible for Account: _____

Address: _____ City: _____ Postal Code: _____ Tel: _____

Do you have an insurance plan that covers orthodontic treatment? Yes No

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	H.I.V./A.I.D.S.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis A, B, or C	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	

If you responded YES to any of the above, please give pertinent information: _____

Are you in good health? _____

Do you have any history of major illness and/or operations? _____

List any drugs or medication now being taken: Please give reasons: _____

List any allergies or drug sensitivities _____

Do you have a tendency to colds? _____ Sore Throats? _____ Ear Infections? _____

Have your tonsils or adenoids been removed? _____ at what age? _____

(Women) Are you pregnant? _____

DENTAL HISTORY

Have you ever been treated for a jaw joint problem, including surgery? Yes No

Have there been any injuries to the face, mouth or teeth? Yes No

Have you ever sucked your thumb or finger? Yes No Until what age? _____

Do you have any speech problems? Yes No

Do you have frequent canker or cold sores? Yes No

Are you a mouth breather? While Asleep: Yes No While Awake: Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Have you ever had a previous orthodontic examination? Yes No

Has any other family member had braces or orthodontic treatments? Yes No

If yes, name of family member if treated in our office: _____

When did you last see your dentist? _____

Reason for orthodontic consultation: _____

INFORMED CONSENT: I hereby give Dr. David Morrow and/or members of his staff permission to collect all relevant personal information and to release this information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary. Such information includes x-rays and other diagnostic records which pertains to the initial condition, diagnosis, proposed treatment or treatment in progress. Financial information will be used specifically for billing purposes. We will provide the highest level of confidentiality with respect to the collection and disclosure of all of your personal information that is provided to us.

Signature _____

Date _____