LEWISBURG ORTHODONTIC ASSOCIATES
ADULT ORTHODONTIC ACQUAINTANCE CARD

Date:_____ Birthdate: _____

Patient's Name: _____ Age: _____ Gender: _____

Nickname / what do you prefer to be called? _____

Address: _____

Cell phone: _____ Secondary phone: _____

Email: _____

Employer: _____ Occupation: _____

Dentist: _____ Physician: _____

Referred by: _____

Marital status: Married Divorced Separated Unmarried

Spouse's Name: _____

Address: _____

Cell phone: _____ Secondary phone: _____

Email: _____

Employer: _____ Occupation: _____

Orthodontic insurance coverage? Yes / No

For HIPAA purposes: Please list any additional adults that can receive information regarding you.

Name	Relationship	Treatment information	Financial information
_____	_____	Yes / No	Yes / No
_____	_____	Yes / No	Yes / No
_____	_____	Yes / No	Yes / No

Patient's signature: _____ Date: _____

ADULT MEDICAL HISTORY

Please read carefully – answer each question accurately

1. Are you in good health? Yes / No

2. Do you have any history of major illnesses? Please list.

_____

3. Please circle any of the following which you have had, past or present:

Pneumonia	Seizures	Gland problems	Cold sores
Asthma	Epilepsy	Unexplained weight loss	Venereal disease/STD
Hay fever	Anemia	Swollen ankles	Glaucoma
Shortness of breath	Hemophilia	Endocrine problems	Hearing impaired
Emphysema	Bleeding disorders	Thyroid disease	Cancer
Dizzy spells	Prolonged bleeding	Diabetes	Chemotherapy
Tuberculosis (TB)	Bruises easily	Ulcer	Radiation therapy
Heart condition	Blood transfusion	GERD/acid reflux	Emotional/depression
Heart murmur	Autoimmune disorder	AIDS/HIV positive	Eating disorder
Heart valve	Celiac or shellfish allergy	Kidney trouble	ADHD/ADD
Chest pain	Bone disorders	Liver disease	Autism Spectrum Disorder
Stroke	Oral/IV bisphosphonates	Jaundice	Congenital disease/genetic
High blood pressure	Arthritis	Hepatitis	disorder or syndrome
Migraines	Artificial joints/implants	Rheumatic fever	

Please explain any of the above issues and any additional conditions not mentioned above:

_____

_____

5. Are you presently, or have you been under a physician's care during the past year? Yes / No
If yes, please explain: _____

6. Are you currently on any medications? Yes / No
Please list: _____

7. Do you have a latex allergy? Yes/No
Do you have any allergies to medications or other materials? Yes / No
Please list: _____

8. Have you ever had a reaction to a local anesthetic? Yes / No
If yes, please explain: _____

9. Have you ever experienced any complication following a dental procedure? Yes / No
If yes, please explain: _____

10. Do you require antibiotics prior to dental procedures? Yes / No

11. Have you ever been told you were not eligible to be a blood donor? Yes / No
If yes, please explain: _____

12. Do you use tobacco (smoke, smokeless, vape)? Yes / No
Alcohol use? Yes/No Illegal drug use? Yes/No

13. Are you pregnant or do you think you may be pregnant? Yes / No

Any other pertinent medical information?

_____

_____

Patient's signature: _____ Date: _____

DENTAL HISTORY

YOUR MAIN REASONS FOR THIS CONSULTATION _____

_____

LAST DENTAL CLEANING? (month, year) _____

Any future dental procedures being planned or discussed (extractions, implants, restorations, etc.)

_____

ANY PREVIOUS INJURIES TO HEAD, FACE, MOUTH, TEETH? YES NO
Brief description and date of injury _____

HISTORY OF THUMB OR FINGERSUCKING? (Until what age? _____) YES NO

SPEECH PROBLEMS? YES NO

DIFFICULTY WITH CHEWING OR SWALLOWING? YES NO

HISTORY OF CLENCHING, GRINDING OR JAW JOINT PAIN? YES NO

HAVE ANY PERMANENT TEETH BEEN REMOVED? YES NO

When and for what reason? _____

HAVE YOU BEEN INFORMED OF ANY CONGENITALLY MISSING TEETH? YES NO

HAVE YOU BEEN INFORMED OF ANY EXTRA TEETH PRESENT? YES NO

ANY PREVIOUS ORTHODONTIC TREATMENT? YES NO

Full braces? retainers? other treatment? _____

HAS THERE BEEN A PRIOR ORTHODONTIC CONSULTATION? YES NO

OTHER INFORMATION YOU FEEL IS PERTINENT _____

_____

_____