Wang Smiles ORTHODONTICS

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ADULT PATIENT ACQUAINTANCE FORM

Patients Name: _____ **Preferred Name:** _____
First Middle Last

Address: _____
Street City State Zip

Birthdate: _____ **Age:** ____ **Gender:** M or F **Marital Status:** Married Separated Divorced Widowed Single

Cell Phone: _____ **Email:** _____

General Dentist: _____ **Office Number:** _____ **Last Visit Date:** _____

Any scheduled or pending treatment? No Yes If yes, please explain _____

How did you learn about our office or whom may we thank for referring you? _____

What is your primary concern? _____

What is your goal with treatment? _____

What treatment option(s) interest you? Invisalign Braces Expanders Retainers

RESPONSIBLE PARTY INFORMATION

Name of person responsible for account: _____

Address: _____
Street City State Zip

Cell Phone: _____ **Email:** _____
Social Security #: _____ **Birthdate:** _____ **Relationship to patient:** _____
Employer: _____ **Occupation:** _____ **Insurance Company Name:** _____
Member or Enrollee ID#: _____ **Group #:**_____ **Do you expect changes to your plan?** YES NO

Person to contact in case of an emergency: _____ Phone:_____

Are you in good health?	____ Yes ____ No	Explain: _____
Any major or unusual illnesses?	____ Yes ____ No	Explain: _____
Currently being treated by a physician?	____ Yes ____ No	Reason: _____
Currently taking medication?	____ Yes ____ No	Reason: _____
Allergies	____ Yes ____ No	List: _____
Drug sensitivity	____ Yes ____ No	List: _____

Please check if you have had any of the following:

____ Anemia	____ Heart Problems	____ Frequent Colds or Flu	____ Are you in a risk group for Aids? ____
____ Blood Disease	____ Tuberculosis	____ Tonsillitis	____ Tonsils Removed: Age: ____
____ Prolonged Bleeding	____ Diabetes	____ Hepatitis	____ Adenoids Removed: Age:____
____ Jaundice	____ Endocrine Problems	____ Asthma	____ Mouth Breathing: While awake? ____
____ Rheumatic Fever	____ Bone Disorders	____ Epilepsy	While asleep? ____
____ Herpes	____ Glaucoma	____ Adenoiditis	

YES	NO	
___	___	Have you ever had any severe head or face injuries? Explain: _____
___	___	Have you had a history of thumb sucking or finger sucking? Age Stopped: _____
___	___	Do you play any musical (wind) instruments? What:_____
___	___	Have you consulted an orthodontist previously?
___	___	Have you had any previous orthodontic treatment When: _____
___	___	Have any family members had orthodontic treatment?

Please check if there is a history of:
_____ Clenching Teeth _____ Grinding Teeth _____ Headaches (more than normal) _____ Jaw Joint Popping _____ Jaw Joint Soreness
_____ Ringing in the Ears _____ Muscular Soreness around Head and Neck _____ Jaw Joint Clicking

Signed:_____ **Date:**_____