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Member American Association of Orthodontists

ROSS Orthodontics

ORTHODONTIC ACQUAINTANCE CARD - Please Print -

DATE _____

DATE OF BIRTH _____

Patient's Name _____ (First Middle Last) Age _____ Sex: Male ☐ Female ☐

Name Patient Prefers to be Called _____

Address _____ (Street City State Zip) Telephone _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Social Security No. _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Name of Spouse _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Name of Person Responsible for Account if Other Than Yourself _____

Do you have dental insurance that covers orthodontic treatment? ☐ Yes ☐ No Name of company _____

Dentist _____ Last Visit to Dentist _____

Physician _____

IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.) _____

_____

MEDICAL HISTORY

Are you in good health? Yes ☐ No ☐ History of Major Illness? Yes ☐ No ☐

Have you been under the care of a physician for a specific problem within the last two years? Yes ☐ No ☐

If so, explain _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ Liver Disease	☐ Epilepsy	☐ Facial Injury
☐ Glaucoma	☐ High Blood Pressure	☐ Bleeding Problems	☐ Bone Disorders
☐ Heart Trouble	☐ Allergies or Asthma	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Rheumatic Fever	☐ Jaw Joint Pain (TMJ)	☐ Night Grinding of Teeth
☐ Hepatitis	☐ AIDS or AIDS related complex (ARC)	☐ Arthritis in any joint	☐ Emotional Problems

List Any Medicines Now Being Taken. Give Reasons _____

_____

List Any Allergies or Drug Sensitivities. _____

_____

Are you pregnant _____ Which month _____

DENTAL HISTORY

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

Have you ever had gum disease? _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Have you had any previous orthodontic treatment? _____ ☐ Yes ☐ No

Do you have an unusual amount of stress in your life? _____ ☐ Yes ☐ No

Reason for seeking orthodontic treatment. (What problem do you wish to have corrected)? _____

_____

Please list any additional information which you feel might be helpful. _____

_____

THANK YOU!

_____

Signature