Adult – Acquaintance Card

Patient Name _____
First Middle Last Nick Name

Birthday _____/ _____/_____ Sex _____ SS# _____

Address _____City _____State_____ Zip_____

Home phone _____ Email address _____

Work Phone _____ Cell phone _____

Employer _____

Physician_____ Dentist _____ Last Seen _____

Who referred you to our practice? _____

Have you ever been a patient of our practice? _____

List family members that are currently in our practice: _____

Names and ages of Children: _____

Spouse Information

Responsible Party Name _____Relationship _____
First Middle Last

Birthday _____/_____/_____ SS# _____

Home Phone _____ Email address _____

Work Phone _____ Cell phone _____

Address _____ City _____State _____ Zip _____

Employer _____

Dental History

Has there been any injuries to the face, mouth or teeth? _____Yes _____ No. Describe _____

Have you ever sucked a thumb or fingers? _____ Yes_____No. Until what age? _____

Do you have any speech problems? _____Yes _____No.

Are you a mouth breather?While awake……_____ Yes _____ No. While asleep? _____ Yes_____ No

Do you have any missing or extra permanent teeth? _____Yes _____No

Has an orthodontist been previously consulted? _____Yes _____ No. Whom? _____

Have you had previous orthodontic treatment? _____Yes _____No.

Have you ever been treated for periododntal disease or TMJ? _____ Yes _____ No

Reason for consultation: _____

_____.

Medical History

Are you in good health? _____Yes ☐ No ☐

Do you have any history of major illness _____Yes ☐ No ☐

Check any of the following for which you have been or are being treated for:

__Diabetes	__Tuberculosis	__Prolonged Bleeding
__Pneumonia	__Anemia	__Endocrine Problems
__Heart trouble	__Epilepsy	__Fainting or Dizziness
__Rheumatic fever	__Asthma	__Nervous Disorders
__Bone disorders	__Kidney Involvement	__Liver Involvement
__Hepatitis	__Hypertention	__Thyroid Problems

Does you have tendency to _____Colds _____ Sore Throats _____ Ear Infections

Have tonsils and adenoids been removed?____ Yes ____ No What age? _____

List any drugs or medications (prescribed or over the counter) now being taken: Give reason _____

Is premedication required for dental procedures?_____ Yes _____No Why? _____

List any allergies or drug sensitivy: _____

Is there any chance that you are pregnant? _____Yes _____ No

Dental Insurance Infornation

Insured's name _____ Insured DOB _____/_____/_____

Insured SS# _____Insured ID# _____

Insurance Company _____

Insurance company address _____

Employer _____

Is policy connected with a Union? _____ Yes _____ No. Name of Union _____ Local # _____

Do you have dual coverage? ____Yes _____ No. If yes, please complete the following secondary insurance information.

Insured's name _____ Insured DOB _____/_____/_____

Insured SS# _____Insured ID# _____

Insurance Company _____

Insurance company address _____

Employer _____

Is policy connected with a Union? _____ Yes _____ No. Name of Union _____ Local # _____

I understand that the information that I have given today is corrected to the best of my knowledge. I also understant that this information will be held in the strictist confidence and it is my responsibility to inform this office of any changes in medical status. In case of seperation/divorce the parent that signs this medical history form will be responsible for all fees incurred at this visit. Please note that all responsible collection, legal costs, including but not limited to finance charges required to collect fees due Batastini Orthodontics, will be borne by the undersigned.

Patient _____ Date _____