

DAVID C. ADAMS, D.D.S., M.S.



SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALIST IN PEDIATRIC DENTISTRY

SM# _____

Adult Orthodontic Acquaintance Form

Date ___/___/___
Patient Name: _____ Sex: _____ Date of Birth: ___/___/___ Age: _____
Res. Address: _____ City: _____ State: _____ Zip: _____
Home Phone Number: _____ Mobile Phone Number: _____
E-Mail Address: _____ Social Security: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____ State: _____ Zip: _____
Business Phone: _____ Drivers License: _____
Spouse Name: _____ Spouse Social Security: _____
Employed by: _____ Occupation: _____
Bus. Address: _____ City: _____ State: _____ Zip: _____
Business Phone: _____ Spouse Date of Birth: _____

Physician: _____ City: _____ Phone: _____
Dentist: _____ City: _____ Phone: _____

Do you have orthodontic insurance? _____
Whom may we thank for referring you to us? _____

MEDICAL HISTORY

Are you in good health? Yes No
At present, are you under medical care? Yes No
Have you ever had a severe illness? Yes No
Have you ever been hospitalized? Yes No

Check those items which have or are now being treated for:

- ARTHRITIS OR JOINT DISEASE
BONE DISORDERS
BLOOD DISORDERS
ANEMIA
HEPATITIS OF JAUNDICE
PROLONGED BLEEDING
SEXUALLY TRANSMITTED DISEASE
AIDS OR HIV POSITIVE
ENDOCRINE PROBLEMS
OTHER ILLNESS
THYROID PROBLEMS
DIABETES
RHEUMATIC FEVER
SCARLET FEVER
FAINTING OR DIZZINESS
HEAD & NECK PAIN
SKIN DISORDERS
CANCER
ULCER OR STOMACH PROBLEM
HEART MURMUR OR DISEASE
STROKE
CONVULSIONS OR SEIZURES
KIDNEY OR BLADDER
GLAUCOMA
RESPIRATORY DISORDERS
TUBERCULOSIS
EPILEPSY
ASTHMA

DRUG SENSITIVITIES

Novocaine Yes No Lidocaine Yes No
Penicillin Yes No Aspirin Yes No
Codeine Yes No Latex Yes No
Other _____ Yes No

List all prescription drugs or medications taken in the last three (3) months (give reasons)

List all allergies or drug sensitivities

Other Illnesses _____

Has anyone in your family had diabetes? Yes No

Women: Is it possible you might be pregnant? Yes No

DENTAL HISTORY

When was your last dental visit? (Approximate Date) ____/____/____

Was all recommended dental work completed? Yes No

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

Do you have any speech problems? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had orthodontic treatment? Yes No

Have you ever had

Oral surgery Yes No

Gum surgery/treatment Yes No

A "bite adjustment" Yes No

A bite plate or splint..... Yes No

Tongue thrust therapy Yes No

Have you ever experienced

Pain in the jaw, ear, or side of face Yes No

Difficulty in jaw opening or closing Yes No

Difficulty in chewing Yes No

Inability to close or open your jaw Yes No

Clicking sounds in the jaw joint Yes No

Do you have frequent headaches? Yes No Frequency _____ Location _____

Habits: Do You

Bite your fingernails? Yes No

Clench or grind your teeth? Yes No

Hold objects with your teeth (pencils, pens, nails, fingernails)? Yes No

Mouth breathe while awake or asleep? Yes No

Other: _____

What would you like orthodontic treatment to accomplish? _____

I acknowledge that the above information is correct and grant this office permission to provide my dental and related medical/surgical treatment as deemed necessary, including diagnostic radiographs. If I ever have a change in health or medications, I will inform the doctor before the next appointment without fail.

Signature: _____ **Name:** _____ **Date:** _____

FINANCIAL TERMS

I will be responsible for the cost of this dental care. I understand, by signing below that if I do not pay, I will be liable for attorney fees and court costs associated with collection of monies due and permission is hereby granted to obtain a credit report. On all past due accounts, a monthly 2.5 % interest charge will be assessed. Non sufficient fund checks are charged a \$35.00 fee. I hereby authorize OrthoBanc, LLC on behalf of David C. Adams, D.D.S., M.S. to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Signature: _____ **Name:** _____ **Date:** _____

Doctor's Notes and Updates: _____

