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

SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALIST IN PEDIATRIC DENTISTRY

SM#_____

ADULT ORTHODONTIC ACQUAINTANCE FORM

Name: _____ Sex:_____ Date of Birth:___/___/_____Age:____
Address: _____ _____
City:_____ State:_____ Zip: _____ **Email Address**: _____
Home Phone:_____ _____ Cell Phone:_____
Social Security: _____ Driver's License:_____
Occupation: _____ Employed by: _____
Bus. Address: _____ _____
City:_____ State:_____ Zip: _____ Bus. Phone: _____

Spouse Name: _____ Date of Birth:_____/_____/_____Age: _____
Spouse Social Security: _____ Drivers license:_____
Occupation: _____ Employed by: _____
Bus. Address: _____ _____
City:_____ State:_____ Zip: _____ Bus. Phone: _____

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

Do you have Dental 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 serious illness? □ Yes □ No _____
Have you ever been hospitalized? □ Yes □ No _____

Check items which you have been, 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
□ LATEX ALLERGIES
□ PROSTHETIC JOINT
□ THYROID PROBLEMS
□ DIABETES
□ RHEUMATIC FEVER
□ SCARLET FEVER
□ FAINTING OR DIZZINESS
□ HEAD & NECK PAIN
□ SKIN DISORDERS
□ CANCER
□ ULCER OR STOMACH PROBLEM
□ DENTAL PHOBIA
□ OTHER_____
□ HEART MURMUR OR DISEASE
□ STROKE
□ CONVULSIONS OR SEIZURES
□ KIDNEY OR BLADDER
□ GLAUCOMA
□ RESPIRATORY DISORDERS
□ TUBERCULOSIS
□ EPILEPSY
□ ASTHMA
□ SENSITIVE GAG REFLEX

DRUG SENSITIVITIES

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

(Please turn page over)

List all prescription drugs taken in the last (3) three months (give reasons): _____
_____
_____
_____

List all allergies or drug sensitivities: _____
_____
_____
_____

Other Illnesses _____
_____
_____

Has anyone in your family had diabetes? ..... ☐Yes ☐No
Women: is it possible that 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
Do you have frequent headaches? ..... ☐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
Frequency _____ Location _____

Habits: Do you…

Bite your fingernails? ..... ☐Yes ☐ No
Hold objects with your teeth?(pencils, pens) ..... ☐Yes ☐ No
Clench or grind your teeth? ..... ☐Yes ☐ No
Mouth breathe while asleep or awake? ..... ☐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:** _____