DR. CAROL M. SUMME

• ORTHODONTIC ADULT ACQUAINTANCE FORM •

Date _____

Patient's Name _____ Age____ Sex _____ Date of Birth _____

Home Address _____ Zip _____ Telephone_____

Name patient prefers to be called_____ Cell_____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you? _____ Email _____

Patient's Occupation _____ Social Security # _____

Employed by_____ School (If Student) _____

Business Address _____ Telephone_____

Spouse's Name _____ Social Security #_____

Occupation _____ Employed by _____

Business Address _____ Telephone_____

Patient's Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced

Names and ages of children_____

Person financially responsible _____

Name of Dental Insurance Co._____ Orthodontic Coverage ❑ Yes ❑ No

• MEDICAL HISTORY •

Do you have any current health problems? ❑ Yes ❑ No Please list _____

Are you under a physician's care now? ❑ Yes ❑ No Please list _____

Are you currently taking any medications? ❑ Yes ❑ No Please list _____

Do you have any history of major illness? ❑ Yes ❑ No Please list _____

Are you pregnant? ❑ Yes ❑ No

Are you taking Birth Control Pills? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

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

Do you have any allergies? ❑ Yes ❑ No Please list _____

Do you have tendency to: ❑ Colds ❑ Sore Throats ❑ Ear Infections ❑ Fever Blisters ❑ Cold Sores (Inside Mouth)

Have you ever been advised to be premedicated for dental appointments? ❑ Yes ❑ No

Are you taking or have ever taken any Bisphosphonate drugs (Fosamax, Actonel, Boniva, Zometa, etc.)? ❑ Yes ❑ No If yes, How long _____

Circle any of the following which you have had or have at present:

Heart Failure	Heart Pacemaker	Hepatitis A (Infectious)	Fainting or Dizzy Spells	Bruise Easily	X-Ray or Cobalt Treatment
Heart Disease or Attack	Heart Surgery	Hepatitis B (Serum)	Nervousness	Emphysema	Arthritis
Angina Pectoris	Artificial Joints (Hip, Knee)	Liver Disease	Psychiatric Treatment	Tuberculosis (TB)	Rheumatism
High Blood Pressure	Anemia	Yellow Jaundice	Sickle Cell Disease	Asthma	Cortisone Medicine
Heart Murmur	Stroke	Blood Transfusion	Glaucoma	Hay Fever	Pain in Jaw Joints
Rheumatic Fever	Kidney Trouble	Drug Addiction	Chemotherapy	Sinus Trouble	Alcoholism
Congenital Heart Lesions	Ulcers	Hemophilia	(Cancer, Leukemia)	Allergies or Hives	Bleeding Problems
Scarlet Fever	Cosmetic Surgery	Fever Blisters	Venereal Disease	Diabetes	
Artificial Heart Valve	A.I.D.S.	Epilepsy or Seizures	(Syphillis, Gonorrhea, etc.)	Thyroid Disease	

Are you allergic or have you reacted adversely to any of the following medications?

❑ Aspirin ❑ Percodan ❑ Erythromycin ❑ Darvon ❑ Local Anesthetic ❑ Valium ❑ Nitrous Oxide ❑ Codeine ❑ Penicillin

Are you aware of being allergic to any other medications or substances? ❑ Yes ❑ No If yes, please list:_____

_____

• DENTAL HISTORY •

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

Have you ever sucked your thumb or fingers? ❑ Yes ❑ No Until what age? _____

Do you have any speech problems? ❑ Yes ❑ No

Are you a mouth breather? While sleeping? ❑ Yes ❑ No

While awake? ❑ Yes ❑ No

Have you ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has an orthodontist been consulted previously? ❑ Yes ❑ No

Have you had any previous orthodontic treatment? ❑ Yes ❑ No

Have you ever had any TMJ (Jaw Joint) problems? ❑ Yes ❑ No

Describe_____

What are you or your dentist most concerned about? (Purpose of this visit) _____

_____

Patient's Signature _____