ADULT ORTHODONTIC ACQUAINTANCE CARD

DATE __________ 20 ____ DATE OF BIRTH __________

PATIENT'S NAME __________ (LAST / FIRST / INITIAL) AGE ______ SEX ______

ADDRESS __________

CITY __________ STATE __________ ZIP ______ TELEPHONE __________

CELL PHONE __________ E-MAIL ADDRESS __________

PATIENT'S DENTIST __________ PHYSICIAN __________

PATIENT'S ORAL SURGEON __________ ORTHODONTIC INSURANCE YES ☐ NO ☐

*IF MULTIPLE INSURANCE, PLEASE LIST PRIMARY CARRIER __________

YOUR OCCUPATION __________

EMPLOYED BY __________ BUS. TELEPHONE __________

BUS. ADDRESS __________ SOCIAL SECURITY # __________

SPOUSE'S NAME __________ OCCUPATION __________

EMPLOYED BY __________ BUS. TELEPHONE __________

BUS. ADDRESS __________ SOCIAL SECURITY # __________

NAMES AND AGES OF CHILDREN IN FAMILY __________

LIST FAMILY MEMBERS WHO HAVE HAD ORTHODONTIC TREATMENT IN THIS OFFICE __________

PERSON RESPONSIBLE FOR ACCOUNT __________

ADDRESS __________ PHONE __________

AS A CREDIT GRANTOR, MAY WE HAVE PERMISSION TO CHECK YOUR CREDIT __________ YES ☐ NO ☐

ARE YOU IN GOOD HEALTH __________ YES ☐ NO ☐

DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS __________ YES ☐ NO ☐

IF YES, PLEASE DESCRIBE __________

DO YOU HAVE ANY MENTAL OR PHYSICAL HANDICAP OR LEARNING DISABILITY WHICH MIGHT LIMIT ABILITY TO FOLLOW INSTRUCTIONS __________ YES ☐ NO ☐

CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED:

DIABETES ______ ☐	TUBERCULOSIS ______ ☐	ENDOCRINE PROBLEMS ______ ☐
PNEUMONIA ______ ☐	ANEMIA ______ ☐	PROLONGED BLEEDING ______ ☐
HEART TROUBLE ______ ☐	EPILEPSY ______ ☐	FAINTING OR DIZZINESS ______ ☐
RHEUMATIC FEVER ______ ☐	ASTHMA ______ ☐	NERVOUS DISORDERS ______ ☐
BONE DISORDERS ______ ☐	KIDNEY INVOLVEMENT ______ ☐	LIVER INVOLVEMENT ______ ☐
HEPATITIS ______ ☐	OTHER ______ ☐	OTHER ______ ☐

DO YOU HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE __________ YES ☐ NO ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS __________

LIST ANY ALLERGIES OR DRUG SENSITIVITY __________

HEIGHT __________ WEIGHT __________

DENTAL HISTORY

HAS THERE BEEN ANY INJURY TO THE MOUTH OR TEETH? __________ YES ☐ NO ☐

DO YOU HAVE DIFFICULTY IN CHEWING? __________ YES ☐ NO ☐

HAVE YOU EVER HAD CLICKING OR PAIN N THE JAW - JOINT AREA? __________ YES ☐ NO ☐

DO YOU FEEL SELF-CONSCIOUS ABOUT YOUR TEETH OR APPEARANCE? __________ YES ☐ NO ☐

HAVE YOU EVER SUCKED A THUMB OPR FINGERS/ UNTIL WHAT AGE? __________ YES ☐ NO ☐

DO YOU HAVE ANY SPEECH PROBLEMS? __________ YES ☐ NO ☐

WHEN WAS YOUR LAST DENTAL APPOINTMENT? __________

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? __________ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? __________ YES ☐ NO ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED __________

WHOM SHALL WE THANK FOR REFERRING PATIENT TO US? __________

REASON FOR CONSULTATION IN THIS OFFICE __________

____
PATIENT'S SIGNATURE

1. ANGLE CLASSIFICATION AND RELATION OF SEGMENTS

	RIGHT SIDE		LEFT SIDE	
	MOLAR	CUSPID	MOLAR	CUSPID
CLASS I				
CLASS II				
DIV II				
CLASS III				

2. DENTITION

RIGHT																	LEFT
				E	D	C	B	A	A	B	C	D	E				
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
				E	D	C	B	A	A	B	C	D	E				

C — CARIES
X — EXTRACTED
S — SUPERNUMERARY
O — CONGENITALLY MISSING
— ATYPICAL FORM
I — IMPACTION
D — DECALCIFICATION

3. ARCH LENGTH —
MAX — EXCESS ☐ ADEQUATE ☐ DEFICIENT ☐ AMT. ____ MM
MAN — EXCESS ☐ ADEQUATE ☐ DEFICIENT ☐ AMT. ____ MM

4. 321 | 123 CROWDED ☐ EVEN ☐ SPACED ☐ AMT. ____ MM
321 | 123 CROWDED ☐ EVEN ☐ SPACED ☐ AMT. ____ MM

5. CROSSBITE — RIGHT ☐ LEFT ☐ MAX. BUCCAL ☐ MAX. LINGUAL ☐

6. OVERBITE — NORMAL ☐ OPEN BITE ☐ CLOSE BITE ☐ ___ %

7. OVERJET — CROSSBITE ☐ EDGE TO EDGE ☐ NORMAL ☐ EXCESSIVE ☐ (AMT. ____ MM)

8. CURVE OF SPEE — DEEP ☐ NORMAL ☐ FLAT ☐ REVERSED ☐

9. MEDIAN LINE — MAXILLARY MIDLINE TO MID-SAGITAL ____ | ____
MANDIBULAR MIDLINE REST ____ | ____ OCCULSION ____ | ____

10. PATH OF CLOSURE — UNRESTRICTIVE ☐ RESTRICTIVE ☐ CONTACT AND MESIALLY ☐
PSEUDO CLASS III ☐ CONTACT AND DISTALLY ☐

11. TMJ — CLICKS ☐ PAIN ☐ RESTRICTIVE MOVEMENT ☐

12. LIP POSTURE — TOGETHER RELAXED ☐ TOGETHER STRAINED ☐ APART ☐

13. LIP MUSCLE TONE — HYPO ☐ NORMAL ☐ HYPER ☐

14. ABNORMAL FRENUM — NONE ☐ UPPER ☐ LOWER ☐

15. TONSILS AND ADENOIDS — NONE ☐ NORMAL ☐ LARGE AND A PROBLEM ☐

16. ERUPTION PATTERN — EARLY ☐ NORMAL ☐ LATE ☐

17. PROFILE — RETRUSIVE ☐ FLAT ☐ PROTRUSIVE ☐ DOUBLE PROTRUSIVE ☐ SATISFACTORY ☐

18. HABITS — TONGUE THRUST ☐ FRONTAL ☐ LATERAL ☐ LIP BITING ☐
FINGER OR THUMBSUCKING ☐ MOUTH BREATHING ☐
FINGERNAIL BITING ☐ LEANING ON CHIN OR FACE ☐ OTHER ____

19. ORAL HYGIENE — EXCELLENT ☐ GOOD ☐ FAIR ☐ NEEDS IMPROVEMENT ☐

20. ESTIMATE

DATE		FEE

RECOMMENDATIONS
RECORDS ☐ CONS. ☐ 20 & 21 ☐
OBSERVATION ☐ OTHER ☐