

ADULT ORTHODONTIC ACQUAINTANCE CARD

DATE _____ 20____

PATIENT NAME _____
Last First Initial

DATE OF BIRTH _____

STREET ADDRESS _____

AGE _____ SEX _____

CITY _____ ZIP _____

TELEPHONE _____

PATIENT'S DENTIST _____ REFERRED BY _____

PATIENT OCCUPATION _____ PHYSICIAN _____

EMPLOYED BY _____ BUS. TEL. NO. _____

SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TEL. NO. _____

BEST TELEPHONE NUMBER TO CALL FOR APPOINTMENT CONFIRMATION _____

BEST TIME TO CALL FOR APPOINTMENT CONFIRMATION _____

IS PATIENT IN GOOD HEALTH? _____ Yes No

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ Yes No

IF SO, PLEASE DESCRIBE _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN _____

LIST ANY DRUG ALLERGIES OR SENSITIVITY _____

HAVE TONSILS OR ADENOIDS BEEN REMOVED? IF SO, WHEN? _____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ Yes No

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? _____ Yes No HOW LONG? _____

DOES PATIENT NORMALLY BREATHE THROUGH MOUTH OR NOSE? _____ WHILE AWAKE — MOUTH NOSE

WHILE ASLEEP — MOUTH NOSE

ARE THERE ANY MISSING OR EXTRA TEETH? _____ Yes No

HAS THE PATIENT EVER SEEN AN ORTHODONTIST BEFORE? _____ Yes No

HAS MOTHER, FATHER, BROTHER OR SISTER EVER HAD ANY ORTHODONTIC TREATMENT? _____ Yes No

PRIMARY REASON FOR CONSULTATION _____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR THIS BILL?
(IF DIFFERENT THAN ABOVE)

Do you have Orthodontic Dental Insurance? Yes No

NAME _____

NAME OF INSURANCE: _____ ADDRESS _____

NAME OF EMPLOYEE: _____

GROUP # _____ PHONE _____

CONTRACT # _____

EMPLOYEE SOC. SECURITY # _____

THANK YOU FOR FILLING OUT ONLY THE FRONT SIDE

I HEREBY AUTHORIZE **ORTHOBANC, LLC**, ON BEHALF OF **THEODORE D. FREELAND, DDS, MS, PC** TO OBTAIN A COPY OF MY CREDIT REPORT FROM A CREDIT REPORTING AGENCY FOR THE PURPOSE OF CONSIDERING PAYMENT OPTIONS.

PARENT OR ADULT PATIENT'S SIGNATURE

HISTORY

1. Describe your problem: _____
2. Which side hurts? Right _____ Left _____ Both _____
3. For how long? _____

4. Is the pain constant or intermittent? _____
5. Is the pain worse in morning, afternoon, evening? _____
6. Does it hurt to move your jaw _____? To chew _____?

7. On the figures below please outline where your pain is.
8. Does your jaw make noise?

Clicking _____

Grinding _____

When? _____

For how long? _____

Other _____

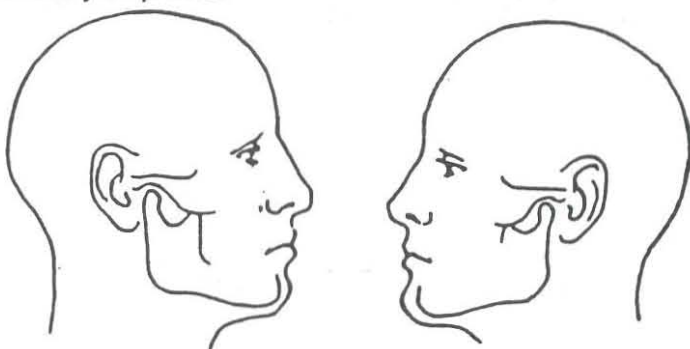
9. Has your jaw ever locked...

Open _____

Closed _____

When _____

How often? _____



10. If your jaw does not make noise or lock now, has it ever in the past? _____

11. Do you have?

a. Headaches _____

b. Neckaches _____

c. Shoulder pain _____

d. Ear pain _____

e. Ringing in the ears _____

f. Dizziness _____

g. Change in hearing _____

12. Do you grind or clench your teeth? _____
- At night? _____ During the day? _____

13. Do you have sore or sensitive teeth? _____

14. Do you have trouble getting to sleep? _____

Do you sleep well? _____

15. Do you consider yourself to be under a lot of stress? _____

Are you nervous or anxious about anything? _____

16. Have you ever had a nervous stomach, ulcers, skin disease? _____

17. Do you have or have you ever had arthritis? _____

18. Does your pain keep you from doing anything? _____

If yes, What? _____

19. Can you remember any injury to your jaw? _____

If yes, describe: _____

20. Do you take medications for the pain? _____

If yes, What? _____

21. Do you take medications for relaxation? _____

If yes, what? _____

22. Have you had any treatments for your problem? _____

If yes, what kind? _____

a. Bite splint _____

b. Medication _____

c. Physical therapy _____

d. Counseling _____

e. Occlusal adjustment _____

f. Orthodontics _____

g. Surgery _____

h. Other _____