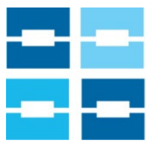

Acadian ORTHODONTICS

Patient Information

Today's Date ______________________ ☐ Male ☐ Female

Name ____
Last First MI

Date of Birth ______________ Age ________ Common Name ______________________

Address ____
Street City/State/Zip

Home # ______________ Cell # ______________ E-mail ______________

School ______________________ Patient's Hobbies/Interests______________________

Responsible Party Information

Name ______________________________ Relationship to Patient ______________
Last First MI

Employer ______________________________ Occupation ______________

Home # ______________ Cell # ______________ E-mail ______________

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Spouse/Other ______________________________ Relationship to Patient ______________

Home # ______________ Cell # ______________ E-mail ______________

Family members previously treated here ______________________________

How did you hear about our office? ______________________________

Medical/Dental History

General Dentist ______________________________ Last Visit ______________

Is the patient under the care of a physician for a specific problem at this time?

____

Physician's Name ______________________________

Taking any prescription medication? ☐ Yes ☐ No If so, which ones?______________________

Are you currently taking a bisphosphonate for osteoporosis?

☐ Yes ☐ No ☐ Fosamax ☐ Boniva ☐ Actonel ☐ Other ______________

List any drug sensitivities ______________________________

Please check all of the following that apply

☐ Asthma ☐ Jaw Joint Pain ☐ Teeth Grinding

☐ Diabetes ☐ Bone Disorders ☐ Heart Condition

☐ Epilepsy ☐ ADD/ADHD ☐ Kidney Problems

☐ Hepatitis ☐ AIDS/HIV ☐ Endocrine Problems

Have you been informed of any missing/extra teeth? ☐ Yes ☐ No

Has an orthodontist previously been consulted? ☐ Yes ☐ No

Has he/she had any previous orthodontic treatment? ☐ Yes ☐ No

Adolescent patients only

Has the patient reached puberty? ☐ Yes ☐ No

Girl: Has she started menstruation? ☐ Yes ☐ No Month/Yr ______________

Boy: Has his voice changed? ☐ Yes ☐ No

______________________________ ______________

Signature of Patient/Parent/Guardian Date