"ADULT"
ACQUAINTANCE CARD
DARSEY-KRIVAN ORTHODONTICS

PLEASE COMPLETE DATE_____

Full Name_____Sex_____
Age____ Birth Date_____Family Dentist_____
Home address_____City_____
State_____Zip_____Hm. Ph#(____)_____Cell Ph#(____)_____
Marital status_____Bus. phone_(____)_____Email _____
Employed by_____Position _____
Name of spouse _____
Spouse employed by_____Position_____
Spouse's Business Phone_____
Who brought your need for orthodontics to your attention? _____
Who told you about our office?_____Do you have orthodontic insurance?____
Person responsible for account _____
Phone_(____)_____Address_____
City_____State_____Zip_____

DENTAL HISTORY

Any previous orthodontic treatment?..... yes__no__
Please explain_____
Is there a history of any injuries to the face, mouth, jaws or teeth?..... yes__no__
Please explain_____
Do gums bleed on brushing?..... yes__no__
Any previous gum treatment?..... yes__no__
History of clenching or grinding teeth during day or night?..... yes__no__
Is there a tendency for mouth breathing or snoring?..... yes__no__
Any history of popping, catching, locking or noise in jaw joint?..... yes__no__
Are frequent headaches a problem?..... yes__no__
What is your main reason for seeking orthodontic treatment? _____
_____

MEDICAL HISTORY

Is patient in good health?..... yes__no__
Have tonsils and/or adenoids been removed?..... yes__no__
Is there a history of rheumatic fever?..... yes__no__
Is there a history of any allergies or drug sensitivities?..... yes__no__
Please list_____
Are you allergic to rubber (latex) or metals (nickel)?..... yes__no__
History of testing HIV positive ?..... yes__no__
History of testing positive for Tuberculosis?..... yes__no__
Have you ever been treated (or plan to start treatment) for
osteoporosis, osteopenia, multiple myeloma or bone cancer?..... yes__no__
Please explain_____
History of any major condition or illness such as hepatitis, diabetes, epilepsy, heart trouble,
hormone or bleeding disorder or others?..... yes__no__
Please explain _____
Please list any medications you are presently taking:_____

Completed by_____
(YOUR SIGNATURE, PLEASE)