ALBERT M. STUSH, JR., D.M.D., M.S.
SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

ADULT ORTHODONTIC ACQUAINTANCE FORM

Date: _____ Birthdate: _____

Patient's Name: _____ Age: _____ Sex: _____

Address: _____
Street City State Zip Code

Telephone: _____ Cell: _____ Email: _____

Driver License# _____ SS# _____

Patient's Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Telephone: _____

May we contact you at your place of employment? _____

When is the best time to contact you? _____

Referred By: _____

Patient's Dentist: _____

Have you visited our office previously? _____

How did you happen to call our office? _____

Patient's Physician: _____

Patient's Oral Surgeon: _____

IF APPLICABLE:
Spouse's Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Telephone: _____ SS#: _____

Spouse's Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Telephone: _____

May we contact your spouse at their place of employment? _____

When is the best time to contact your spouse? _____

Who is responsible for payment of account? _____

Orthodontic insurance coverage? Yes _____ No _____ Company _____

Policy # _____ Group # _____

** This information may be used to obtain a credit history report. **

ADULT MEDICAL HISTORY

PLEASE READ CAREFULLY - ANSWER EACH QUESTION ACCURATELY

1. Are you in good health?
_____ Yes _____ No _____

2. Do you have any history of major illness?
_____ Yes _____ No _____

3. Please draw a circle around any of the following which you have had or may have at present.

Heart Disease	Pneumonia	Tuberculosis (TB)	Attention Deficit Disorder
Heart Condition	Gland problems	Unexplained weight loss	Seizures
Chest pains	Hemophilia	Bone disorders	Endocrine problems
High blood pressure	Bleeding disorders	Diabetes	Dizzy spells
Shortness of breath	Bruises easily	Ulcers	AIDS
Swollen ankles	Prolonged bleeding	Kidney trouble	AIDS related complex
Artificial heart valve	Anemia	Liver disease	HIV positive
Congenital heart disease	Blood transfusion	Jaundice	Cold sores
Heart murmur	Arthritis	Hepatitis	Genital herpes
Rheumatic fever	Asthma	Thyroid disease	Venereal disease
Stroke	Hay fever	Glaucoma	Cancer
Chemotherapy	Emphysema	Epilepsy	Radiation therapy
Emotional problems	Implant prosthesis	ADHD	Hyperactivity
Artificial joints/Implants	Heart valve	Osteoporosis	Multiple Sclerosis

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. *IF IN DOUBT, CIRCLE YES.*

4. Are you presently, or have you been under the care of a physician during the past year? If yes, why?	**YES**	**NO**
5. Are you presently taking any medicine or drugs? Please list.	**YES**	**NO**
6. Are you allergic to any medicine or materials? Please list.	**YES**	**NO**
7. Have you ever had a reaction to local anesthetic? Please list.	**YES**	**NO**
8. Have you ever experienced any complication or illness following a dental treatment?	**YES**	**NO**
9. Do you have any diseases or conditions not listed above?	**YES**	**NO**
10. Have you ever been told you were not eligible to be a blood donor?	**YES**	**NO**
11. Do you use tobacco? Smoke? Smokeless? Frequency? _____	**YES**	**NO**
12. WOMEN ONLY: Are you pregnant or do you think you may be pregnant? If yes, circle trimester: 1st 2nd 3rd	**YES**	**NO**
13. Are you currently taking medication (Bisphosphonate Therapy) for osteoporosis?	**YES**	**NO**

Patient Comments:

Signature of Patient _____ Date _____

Orthodontist's Comments:

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ACQUAINTANCE FORM PAGE 2

- YOUR MAIN REASON FOR THIS CONSULTATION?_____

_____

- WHOM MAY WE THANK FOR RECOMMENDING US? _____

_____

- PATIENT'S LAST DENTAL APPOINTMENT? (month, year) _____

- ANY PREVIOUS INJURIES TO HEAD, FACE, MOUTH, TEETH? YES NO

If yes, can you describe the injury? _____

_____

- IS THERE A HISTORY OF THUMB OR FINGERSUCKING? YES NO

If yes to the above question, until what age? _____

- ARE THERE ANY SPEECH PROBLEMS? YES NO

- HAVE YOU BEEN INFORMED OF ANY MISSING TEETH? YES NO

- HAVE YOU BEEN INFORMED OF ANY EXTRA TEETH PRESENT? YES NO

- HAVE ANY PERMANENT TEETH BEEN REMOVED? YES NO

If yes, for what reason? _____

- IS THERE ANY DIFFICULTY WITH CHEWING, SWALLOWING? YES NO

- ANY HISTORY OF CLENCHING, GRINDING? YES NO

- PREVIOUS HISTORY OF ORTHODONTIC TREATMENT? YES NO

If yes, full braces?, retainers?, other treatment?

- HAS THERE BEEN AN ORTHODONTIC CONSULTATION BEFORE? YES NO

- WHAT CONCERNS YOU MOST ABOUT ORTHODONTICS? _____

_____

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- HOBBIES, MUSICAL INSTRUMENTS, INTERESTS? _____

_____

- OTHER INFORMATION YOU FEEL IS PERTINENT? _____

_____

_____