Vaughan ORTHODONTICS

Dr. Austin Chen
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Certified Specialist in Orthodontics and Dentofacial Orthopedics

Adult Orthodontic Acquaintance Form

Name: _____ Date: _____

Date of Birth: ____ MM ____ DD ____ YY Age: _____ Sex: _____ Occupation: _____

Home Address: _____ City: _____ Postal: _____

Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Email Address: _____

Patient's Dentist: _____ Physician: _____ Physician's Tel: _____

Who may we thank for referring you? _____

Person responsible for account: _____

If person other than yourself is responsible for account, please indicate relationship: _____

Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Disease	□ Yes □ No	Sexually Transmitted Diseases	□ Yes □ No	Asthma	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Blood Pressure	□ Yes □ No	Arthritis	□ Yes □ No
Artificial Joints	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	Other _____	

If you responded YES to any of the above questions, please give pertinent information: _____

_____

Are you in good health? _____ If you responded 'No', please explain: _____

List any drugs or medications now being taken: Please give reasons: _____

Do you have any history of major illness and/or operations? _____

List any allergies or drug sensitivities: _____

Have your tonsils or adenoids been removed? □ Yes □ No At what age? _____

Do you have a tendency to colds? □ Yes □ No Sore Throats? □ Yes □ No Ear Infections? □ Yes □ No

(Women) Are you pregnant? □ Yes □ No

DENTAL HISTORY

Reason for orthodontic consultation: _____

Have you ever been treated for a jaw joint problem, including surgery? □ Yes □ No

Have there been any injuries to the face, mouth or teeth? □ Yes □ No Please describe: _____

Do you have any speech problems? □ Yes □ No

Do you have frequent canker or cold sores? □ Yes □ No

Are you a mouth breather? While Asleep: □ Yes □ No While Awake: □ Yes □ No

Have you been informed of any missing or extra permanent teeth? □ Yes □ No

Have you ever had a previous orthodontic examination? □ Yes □ No

Do you want orthodontic treatment? □ Yes □ No

Has any other family member had braces or orthodontic treatment? □ Yes □ No

Please name the family member if treated in our office: _____

When did you last see your dentist? _____

I hereby give Dr. Austin H. Chen and/or members of his staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____

Signature Date