ANDREW B. BROWN, D.D.S., M.S.
Welcome to Our Office

ADULT ORTHODONTIC ACQUAINTANCE CARD

DATE _____

— Please Print —

Date of Birth _____

Patient's Name _____ Age _____ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers to be Called _____ Home Telephone Number _____

Address _____
Street City State Zip

Cell Phone _____ Email _____

Marital Status Married ☐ Single ☐ Divorced ☐ Soc. Sec. No. _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Name of Spouse _____ Social Security Number _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Name of Person Responsible for Account if Other Than Yourself _____

Do you have dental insurance that covers orthodontic treatment? Yes _____ No _____

Name of Insurance Company _____

Dentist _____ Physician _____

Last Visit to Dentist _____

Whom may we thank for referring you? _____

MEDICAL HISTORY

Are you in good health? Yes ☐ No ☐ History of Major Illness? Yes ☐ No ☐ If so, what _____

Are you presently under the care of a physician for a specific problem? Yes ☐ No ☐

If so, explain _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ Pregnant	☐ Epilepsy	☐ Head/Facial Injury	☐ HIV
☐ Glaucoma	☐ High Blood Pressure	☐ Bleeding Problems	☐ Bone Disorder	
☐ Heart Trouble	☐ Allergies or Asthma	☐ Diabetes	☐ Endocrine Problems	
☐ Kidney Disease	☐ Rheumatic Fever	☐ Jaw Joint Pain (TMJ)	☐ Night Grinding of Teeth	
☐ Hepatitis/Liver Disease	☐ Venereal Disease	☐ Arthritis	☐ Emotional Problems	

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ ☐ Yes ☐ No

Have you ever had gum disease? _____ ☐ Yes ☐ No

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

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Have you or anyone in your family had any previous orthodontic treatment? _____ ☐ Yes ☐ No

If so, by whom? _____

Please list any family members treated here _____

Do you have an unusual amount of stress in your life? _____ ☐ Yes ☐ No

Reason for seeking orthodontic treatment (What problem do you wish to have corrected) _____

_____

Please list any additional information which you feel may be helpful _____

_____

THANK YOU

Member
American Association of
Orthodontists

_____
Patient's Signature