ADULT ORTHODONTIC ACQUAINTANCE FORM

INFORMATION

Name: First_____Last_____

Date of Birth: D_____M_____Y_____ Age:_____ E-mail Address:_____

Address:_____ City:_____ Postal Code:_____ Tel:_____ Cell Tell:_____

Dentist:_____ Date of Last Visit:_____ Family Physician: _____ Tel:_____

How did you hear about MCO Orthodontics? _____

Person Responsible for Account: _____

MEDICAL HISTORY

Are there any medical conditions and/or operations in the past or present that we should be aware of? ☐ Yes ☐ No

(If Yes) Please specify:

_____

_____

Are you currently taking any drugs or medication? ☐ Yes ☐ No Please List: _____

Do you have any allergies or drug sensitivities? ☐ Yes ☐ No Please List: _____

(Women) Are you pregnant? ☐ Yes ☐ No

DENTAL HISTORY

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

Have you had any injuries to your face, mouth or teeth? ☐ Yes ☐ No Please specify_____

Do you have difficulties with speaking? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Have you ever seen a Periodontist or been told your gums/bone require special treatment? ☐ Yes ☐ No

Do you breathe predominantly through your mouth? ☐ Yes ☐ No

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

Do you want orthodontic treatment? ☐ **Yes** ☐ **No**

Have you ever had an orthodontic examination? ☐ Yes ☐ No

Have any other family members ever had braces or orthodontic treatment? ☐ Yes ☐ No

Reason for orthodontic consultation: _____

RELEASE OF INFORMATION: I hereby give MCO Orthodontics permission to release information concerning my dental and/or orthodontic health to my family physician, dentist, any other dentist specialist or my insurance company as is deemed necessary, and for teaching as well as internal office purposes. This information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

_____

Signature Date

Thank you for choosing MCO Orthodontics!