BRUNO ORTHODONTICS
CREATING BEAUTIFUL SMILES

ADULT ORTHODONTIC ACQUAINTANCE FORM

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Clawson, MI 48017
248-435-2000

Date: _____

Patients Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Referred by: _____

Residence Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Email Address: _____

Family Dentist: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Last Visit: _____ Treatment Rendered: _____

Have you seen another orthodontist? ❒ Yes ❒ No If yes, Name:_____

Family Physician: _____ Address: _____ Phone: _____

Date of Last Visit: _____ Treatment Rendered: _____

Patient's Occupation: _____ Business Phone: _____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Person responsible for financial matters (if other than yourself): _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Company: _____ Orthodontic Coverage: ❒ Yes ❒ No

Insured's Name: _____ Group #: _____

Medical Insurance Company: _____

Insured's Name: _____ Group #: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Phone: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

AAO American Association of Orthodontists

PLEASE TURN OVER AND COMPLETE OTHER SIDE

www.brunoortho.com

MEDICAL HISTORY

General Health Status: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Birth Defects: _____

Are you currently under a physician's care? ❑ Yes ❑ No If yes, explain: _____

Drugs or medications currently being taken (Drug and Dosage): _____

Are you taking or have you taken oral bisphosphonates for osteoporosis or Paget's disease? ❑ Yes ❑ No

Drug allergies? _____ Latex allergy? ❑ Yes ❑ No

Are you pregnant or a nursing mother: ❑ Yes ❑ No Are you anticipating becoming pregnant? ❑ Yes ❑ No

Do you require antibiotic premedication for dental procedures? ❑ Yes ❑ No If yes, explain: _____

Do you have a history of infective endocarditis, received a cardiac transplant, artificial heart valve, or a joint replacement? ❑ Yes ❑ No

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING ITEMS AND DATE EACH

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Adenoids removed	❑	❑	_____	Heart disorder	❑	❑	_____	Congenital heart disease	❑	❑	_____	Hearing difficulties	❑	❑	_____
AIDS	❑	❑	_____	Hepatitis	❑	❑	_____					Neurosis	❑	❑	_____
Allergies	❑	❑	_____	Hospitalized	❑	❑	_____	Convulsions	❑	❑	_____	Polio	❑	❑	_____
Anemia	❑	❑	_____	Hyperactivity	❑	❑	_____	Diabetes	❑	❑	_____	Rheumatic Fever	❑	❑	_____
Arthritis	❑	❑	_____	Hypertension	❑	❑	_____	Dizziness	❑	❑	_____	Scoliosis	❑	❑	_____
Asthma	❑	❑	_____	Injuries	❑	❑	_____	Emotional	❑	❑	_____	Seizures	❑	❑	_____
Blood disorder	❑	❑	_____	Jaundice	❑	❑	_____	Endocrine disorder	❑	❑	_____	Speech difficulties	❑	❑	_____
Bone disorder	❑	❑	_____	Kidney disorder	❑	❑	_____	Epilepsy	❑	❑	_____	X-ray treatment (i.e. radiation treatment)	❑	❑	_____
Breathing difficulties	❑	❑	_____	Liver disorder	❑	❑	_____	Epistaxis (nosebleed)	❑	❑	_____				
Bronchitis	❑	❑	_____	Lung disorder	❑	❑	_____	Eye disorders	❑	❑	_____	Tonsils (removed)	❑	❑	_____
Chicken Pox	❑	❑	_____	Measles	❑	❑	_____	Fainting spells	❑	❑	_____	Tuberculosis	❑	❑	_____
Cerebral Palsy	❑	❑	_____	Mumps	❑	❑	_____	Glaucoma	❑	❑	_____	Venereal disease	❑	❑	_____

Other: _____

Please give greater details to any above "yes" responses: _____

_____

DENTAL HISTORY

Are you currently under the care of another dental specialist? ❑ Yes ❑ No If yes, Name? _____

Please list any injuries to the face or teeth: _____

How often do you brush your teeth each day? _____ Do you floss regularly? ❑ Yes ❑ No

Oral habits (smoking, nail biting, lip biting, thumb/finger sucking)? _____

Breathing method: ❑ By nose ❑ By mouth Do you have difficulty breathing at night? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No When do you find yourself doing it most? ❑ Daytime ❑ Nighttime

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT? _____

_____

To the best of my knowledge, the above statements are complete and correct. No information has been omitted or withheld.

_____ _____

Signature of Patient Date