HUMBERTOWN ORTHODONTICS

Dr. Harold Rosenberg
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Certified Specialist in Orthodontics and Dentofacial Orthopedics

Adult Orthodontic Acquaintance Form

Patient Name:

Who may we thank for referring you? _____

Person responsible for account: _____

Home Tel: _____ Cell: _____ Work Tel: _____

Contact e-mail:_____

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? _____

(Women) Are you pregnant? □ Yes □ No

DENTAL HISTORY

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:	_____
Have you ever sucked your thumb or finger?		□ Yes □ No	Until what age?	_____
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? _____

Reason for orthodontic consultation: _____

I hereby give Dr. Harold Rosenberg 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