Montclair Orthodontics

Edward D. Gold, DDS & Hadley A. Rubino, DMD

218 Lorraine Avenue

Upper Montclair NJ, 07043 **973-744-1912** **www.montclair-orthodontics.com**

ORTHODONTIC ACQUAINTANCE FORM: ADULT

Date_____

Patient's name _____

Title First Middle Last

Address _____

Street City Zip

Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Employer_____Occupation _____

Birthdate_____ Gender_____ Social Security # _____

Marital Status (circle one) Single Married to _____ Widowed Separated Divorced

Names and ages of any children _____

Hobbies and Interests _____

Do you play a musical instrument? _____ Which one(s)? _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION (if different from patient)

Name_____

Title First Middle Last

Address _____

Street City Zip

Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Social Security #_____ Relationship to Patient _____

Employer_____Occupation _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete address_____

Street City Zip

Phone Number(s) _____

MEDICAL HISTORY

Physician _____Date of last visit_____

Address _____Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is patient taking any medication? _____

Yes No Is patient allergic to any medication? _____

Yes No Does patient have a history of a major illness?_____

Yes No Has patient had any operations or been hospitalized? _____

Yes No Has patient ever been involved in a serious accident? _____

Yes No Has patient seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Herpes	Psychiatric Care
Anemia	Dizziness	High Blood Pressure	Radiation/Chemotherapy
Anxiety/Nervousness	Epilepsy	HIV / AIDS	Rheumatic Fever
Arthritis	Gastrointestinal Disorders	Kidney problems	Seizures
Asthma or Hayfever	Heart Problems	Neurological Disorders	Tuberculosis
Bone Disorders	Heart Murmur	Pneumonia	Tumor or Cancer
Congenital Heart Defect	Hepatitis/Liver problems	Prolonged Bleeding	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____Date of last visit_____

What is the patient's primary concern? _____

Yes No Is patient presently in any dental pain? _____
Yes No Has patient ever experienced any unfavorable reaction to dentistry? _____
Yes No Has patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Has patient had tonsils and/or adenoids removed? When? _____
Yes No Is any part of patient's mouth sensitive to temperature? Where? _____
Yes No Is any part of patient's mouth sensitive to pressure? Where? _____
Yes No Do patient's gums bleed during brushing? _____
Yes No Has patient had any type of thumb, tongue or pacifier habit? Until what age? _____
Yes No Is patient a mouth breather? _____
Yes No Does the patient snore? _____
Yes No Has patient ever seen an orthodontist? If yes, who and when? _____
Yes No Does patient have a positive attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do patient's teeth or jaws ever feel uncomfortable upon waking in the morning? _____
Yes No Are you aware of patient's jaw clicking or popping? _____
Yes No Are you aware of clenching teeth during the day? _____
Yes No Has patient ever been told that they grind their teeth? _____
Yes No Does patient have "tension" headaches? _____
Yes No Does patient have a learning disability or need extra help with instructions? _____
Yes No Is patient sensitive or self-conscious about teeth / smile? _____

Female Patients only:
Yes No Is patient pregnant? _____

AUTHORIZATION

I authorize my diagnostic records to be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Gold and Dr. Rubino to perform a complete orthodontic evaluation.

Signature: _____Date: _____