ADULT ACQUAINTANCE CARD

Michael L. Keim, D.D.S., P.C.
Orthodontist

DATE________________

PATIENT'S NAME ____ DOB_______/_______/_______
LAST FIRST MIDDLE INITIAL

NICKNAME ____________________________ SEX_______ HOME #__________________________________ CELL #____________________

ADDRESS ____ EMAIL ______________________________________

CITY ____ STATE ____________________ ZIP CODE_____________________

OCCUPATION ____________________________ EMPLOYER _____________________________________ WORK # ___________________

SPOUSE ____ EMAIL ______________________________________

OCCUPATION ____________________________ EMPLOYER _____________________________________ CELL #_____________________

LIST ANY FRIENDS OR RELATIVES SEEN IN THIS OFFICE ____

PERSON(S) RESPONSIBLE FOR ACCOUNT ____

ORTHODONTIC INSURANCE COMPANY, IF ANY ____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____

PHYSICIAN'S NAME____

ARE YOU IN GOOD HEALTH? YES_____ NO_____

LIST CURRENT MEDICATIONS____

HAVE YOUR TONSILS AND ADENOIDS BEEN REMOVED? YES_____ NO_____

CHECK (✓) ANY KNOWN HISTORY AND EXPLAIN BELOW:

_____ALLEGIES TO MEDICATIONS
_____ARTHRITIS
_____CONVULSIONS
_____DIABETES
_____EPILEPSY
_____EXCESSIVE BLEEDING
_____GENETIC DISORDERS
_____GLAUCOMA / EYE TROUBLE
_____HEART DISEASE
_____HEART VALVE PROBLEMS
_____HEPATITIS
_____HIGH BLOOD PRESSURE
_____HIV INFECTION/AIDS
_____PSYCHIATRIC CARE
_____RHEUMATIC FEVER
_____SINUS PROBLEM
_____TUBERCULOSIS

MAJOR ILLNESSES/OTHER MEDICAL INFORMATION____

____

DENTIST'S NAME____

DATE OF LAST DENTAL EXAM ___________________________________

HAVE YOU SEEN AN ORTHODONTIST PREVIOUSLY? YES_____ NO_____ IF SO, WHOM?_________________________ WHEN?_________

CHECK (✓) ANY OF THE APPROPRIATE DESCRIPTIONS OF PATIENT:

_____ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS
_____BREATHING MOSTLY THROUGH MOUTH
_____LIPS APART AT REST
_____PERIODONTAL (GUM) PROBLEMS
_____EXTRA TEETH
_____MISSING PERMANENT TEETH
_____INJURED TEETH DUE TO FALL OR ACCIDENT
_____SEVERE HEAD OR FACE INJURY
_____FREQUENT HEADACHES
_____PAIN, CLICKING, OR POPPING OF JAWS OR EARS
_____LOCKING OR CATCHING OF JAW
_____GRINDING OR CLENCHING OF TEETH

_____OTHER ____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY ___________________________________ DATE _______________________________

UPDATE__________ __________ __________ __________ __________ __________ __________ __________