MATTHEW L. MOLITOR, *D.D.S., M.S.*

A

ORTHODONTIC AQUAINTANCE FORM

Patient's Information:

Mr. Mrs. Ms. Miss Dr. Date _____

Name _____

Address _____

Birthdate ____/____/____ Age_____ Home Phone (_____) - _____ - _____

Cell Phone (_____)-_____-_____ Email Address _____

Physician's Name _____ Dentist's Name _____

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

Person Responsible for this Account:

Name _____Relationship_____

Billing Address _____Email Address_____

Employer _____ Work # (_____) - _____ - _____

Employer's Address: _____

MEDICAL HISTORY

Have you been diagnosed or treated for any of the following?

Diabetes	Fainting	Endocrine Disorder
Epilepsy	Rheumatic Fever	Bone Disorder
Asthma	Heart Trouble	HIV
Arthritis	Cerebral Palsy	Hepatitis
Anemia	Prolonged Bleeding	

Yes No

Are you presently under physician's care?
For? _____

Are you taking any medications? _____
_____

Have you ever had an unusual reaction to medication?
_____

Are you allergic to anything? _____
_____

Have you ever had major surgery? For?_____
_____

Tonsils and adenoids removed? _____

Do you have a chronic problem with your:
Kidneys Heart Lungs Liver

Do you have any medical problems not mentioned above?

Describe: _____
_____
_____

DENTAL HISTORY

Yes No

Do you breathe predominantly through your mouth?
Do you have any speech problems?
Are you aware of any tooth grinding or clenching during the day or at night?
Do you have frequent headaches?
Do you have problems with your jaw joints?
Are you bothered with chronic shoulder or neck pain?
Do your gums bleed when brushing or flossing?
Have you ever had a severe head or facial injury?
Have you ever had a previous orthodontic consultation or treatment? _____
_____
Have your wisdom teeth been extracted?
Do you chew on both sides of your mouth?

How many times a month do you floss your teeth? _____

What concerns you most about the thought of having braces?
Appearance Cost Duration of treatment Pain
Success of treatment Other _____

Please describe the problem and/or reason for seeing an orthodontist:
_____
_____
_____

The above information is true and correct and I have received a copy of this office's Notice of Privacy Policy.

Signature: _____ Date: _____