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

A

ORTHODONTIC AQUAINTANCE FORM

Patient's Information: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Today's Date _____/_____/_____

Name _____ Birth Date _____/_____/_____

Address _____

Primary Phone (_____)-_____-_____☐ Home ☐ Cell

Additional Phone # (_____)-_____-_____☐ Home ☐ Cell

Email Address _____

Physician's Name _____ Dentist's Name _____

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

Okay to receive text and email messages for reminders and correspondence? ☐ **Yes** ☐ **No**

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? If no, please select "None" ☐ **NONE**

☐ 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
☐	☐	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 us?

_____

_____

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

Signature: _____ Date: _____