Sam H. Arazie, D.M.D., M.S.D., P.A.
Welcome to Our Office

DATE _____ 20 ___

ADULT ORTHODONTIC ACQUAINTANCE CARD

—Please Print— DATE OF BIRTH _____

Name _____ Age ___ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers to be Called _____

Address _____ Telephone _____
Street City State Zip

Marital Status: Married ☐ Single ☐ Divorced ☐ Social Security No. _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Name of Spouse _____

Occupation _____ Employer _____

Business Address _____ Telephone _____

Responsible Party _____ Email _____

Do you have dental insurance that covers orthodontic treatment? Yes ____ No ____

Dentist _____ Physician _____

Last Visit to Dentist _____

IS THERE SOMEONE OTHER THAN YOUR DENTIST THAT WE MAY THANK FOR REFERRING YOU TO OUR OFFICE? (FRIENDS, NEIGHBORS, PATIENTS, ETC.?) _____

_____

MEDICAL HISTORY

Are you in good health? Yes ☐ No ☐ History of Major Illness? Yes ☐ No ☐

Are you presently under the care of a physician for a specific problem? Yes ☐ No ☐

If so, explain _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ Liver Disease	☐ Epilepsy	☐ Facial Injury
☐ Glaucoma	☐ High Blood Pressure	☐ Bleeding Problems	☐ Bone Disorders
☐ Heart Trouble	☐ Allergies or Asthma	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Rheumatic Fever	☐ Jaw Joint Pain (TMJ)	☐ Night Grinding of Teeth
☐ Hepatitis	☐ AIDS or AIDS related complex (ARC)	☐ Arthritis	☐ Emotional Problems

List Any Medicines Now Being Taken. Give Reasons _____

_____

List Any Allergies or Drug Sensitivities. _____

_____

DENTAL HISTORY

Have you ever had gum disease? _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Have you had any previous orthodontic treatment? _____ ☐ Yes ☐ No

If so, by whom? _____

Do you have an unusual amount of stress in your life? _____ ☐ Yes ☐ No

Reason for seeking orthodontic treatment.(What problem do you wish to have corrected)? _____

_____

Please list any additional information which you feel might be helpful. _____

_____

THANK YOU

Member American Association of Orthodontists

_____
Patient's Signature