Dr. Brian N. Laski
Dr. Stacey J. Kirshenblatt
Certified Specialists in Orthodontics
and Dentofacial Orthopaedics

Adult Orthodontic Acquaintance Form

Patient's Name: _____ Email: _____
Date of Birth: ___DD ___MM ____YY Age: _____ Sex: _____ Occupation: _____
Home Address: _____ City: _____ Postal Code: _____
Home Tel: _____ Cell: _____ Work Tel:_____
Patients Dentist: _____ Who may we thank for referring you?_____
Physician:_____ Physicians Tel:_____
If a person other than yourself is responsible for account, please indicate name & relationship: _____
Do you have an insurance plan that covers orthodontic treatment? _____

MEDICAL HISTORY – HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

□ Rheumatic Fever	□ Asthma	□ Liver Disease
□ Heart Murmur / Heart Defect	□ Arthritis	□ Leukemia / Cancer
□ Artificial Heart Valve	□ Blood Pressure	□ Psychiatric Disorders
□ Hepatitis A, B, or C	□ Kidney Disorder	□ Artificial Joints
□ Tuberculosis	□ Sexually Transmitted Diseases	□ Other _____
□ H.I.V. / A.I.D.S.	□ Prolonged Bleeding	□ **None of the Above**
□ Diabetes	□ Kidney Disorder	

If you checked off any of the above, please give pertinent details: _____
_____
List any drugs or medications being taken (Please give reason): _____
Do you have any history of major illness and/or operations? _____
List any allergies or drug sensitivities: _____
Have your tonsils or adenoids been removed? Yes / No If Yes, at what age: _____
Do you have a tendency to colds, sore throats or ear infections? Yes / No Please indicate: _____
(Women) Are you pregnant? Yes / No / Unsure

DENTAL HISTORY – Please circle

Do you have any jaw joint pain? Yes / No _____
Have you ever been treated for a jaw joint problem, including surgery? Yes / No
Have there been any injuries to your face, mouth or teeth? Please describe? Yes / No _____
Have you ever sucked your thumb or finger? Yes / No Until what age:_____
Do you have any speech problems? Yes / No
Do you get frequent canker or cold sores? Yes / No
Are you a mouth breather? Yes / No Asleep/awake
Have you been informed of any missing or extra permanent teeth? Yes / No
Please name any family members treated in our office: _____
When did you last see the family dentist? _____
Reason for orthodontic consultation? _____
Have you ever had a previous orthodontic examination/ Treatment? If so when? _____

I hereby give Dr. Brian Laski and/or Dr. Stacey Kirshenblatt and/or members of their staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment plan or treatment in progress.
I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____
Signature of Patient Date