WESTWALK ORTHODONTIC GROUP, P.C.

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David A. Romeo, D.M.D. --- Gary J. Romeo, D.M.D. --- Stephen N. Cagliostro, D.M.D.

APPT:
Dr. _____
Date _____
Time

ADULT
ORTHODONTIC ACQUAINTANCE FORM

Acct. # **Case #** *this box for office use only*

Patient Name:_____ **Title**____ **Nickname**_____
first *m.i.* *last*
Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone No._____ **Email:**_____
area code *home* *cell* *cell phone carrier*
Birth Date:_____ **Sex:**____ **Social Sec.#**_____ **Who may we thank for referring you:**_____

Dentist:_____ **Physician:**_____ **Occupation:**_____

Employer_____ **Employers Address:**_____ **Phone**_____

Person Responsible for Account_____ **Address**_____
if not self *if different from above*
Responsible Person's Soc. Sec. #_____ **Responsible Person's Employer**_____

Responsible Person's Employer's Address_____ **Phone:**_____

Medical History

	YES	NO		YES	NO
• Heart Murmur	☐	☐	Congenital Heart Abnormality	☐	☐
• Rheumatic/Scarlet Fever	☐	☐	Hepatitis	☐	☐
• Jaundice	☐	☐	Bleeding Problems	☐	☐
• Bruise Easily	☐	☐	Do you Smoke	☐	☐
• Tonsils/Adenoids removed	☐	☐	Frequent Headaches	☐	☐
• Allergies	☐	☐	If Yes, To what	_____	
• Allergies to Medications	☐	☐	If Yes, Type	_____	
• Do You Take Medication	☐	☐	If Yes, Name	_____	
• Have you had major illness	☐	☐	If Yes, What	_____	
• Have you been hospitalized	☐	☐	If Yes, for what	_____	

• Other pertinent medical history_____

Dental History

	YES	NO
• Have you had injuries to face or jaw	☐	☐
• Is there clicking, popping, or pain in jaw joint	☐	☐
• Are there any speech problems	☐	☐
• Have any teeth been lost or broken	☐	☐
• Are there problems chewing, swallowing, or talking	☐	☐
• Do gums bleed on brushing or feel sore		

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	YES	NO
• **Are there any finger sucking habits/nailbiting**	☐	☐
• **Have you been told of any extra or missing teeth by your Dentist**	☐	☐
• **Do you brush your teeth at least every morning and night**	☐	☐
• **Do you grind your teeth at night**	☐	☐
• **Have you been told that you snore while sleeping**	☐	☐
• **Do you play a musical instrument**	☐	☐
• **Are you aware or concerned about appearance of your teeth**	☐	☐
• **Are you interested in wearing orthodontic appliances to correct your teeth**	☐	☐
• **Has any other family member worn braces**	☐	☐

- **In your own words how would you describe the problem**_____

Signature ***Date***