Smiles Hollywood Orthodontics™

Where Our Patients are the Stars!™

Stephanie Crise DDS, MS Jessica Downs DDS, MS
Specialists in Orthodontics for Children & Adults

Date____________

Acquaintance Record-Adult

Patient's Name ____

Sex ____________ Nickname _____________________________ Age __________________ Date of Birth _______________________

List any hobbies, sports or activities enjoyed: ____

List names & ages of children, if any: ____

How did you hear about our office? ____

Medical History/Information

Please indicate YES if You currently have or have ever had any of the following medical conditions.

	Yes	No		Yes	No		Yes	No
Heart Disease?			Asthma or Hay Fever?			Nervous/Emotional Problems?		
Heart Murmur or Defect?			Tuberculosis?			High or Low Blood Pressure?		
Respiratory Disease?			Any Broken Bones?			Problems with Wound Healing?		
Blood Disease?			Prolonged Bleeding?			Chemotherapy?		
Liver Disease?			Yellow Jaundice?			Osteoporosis?		
Thyroid Disease?			Radiation Therapy?			Rheumatic/Scarlet Fever?		
Kidney Disease?			Mononucleosis?			Rheumatism or Arthritis?		
Venereal Disease?			Hepatitis?			Are You Currently Under Medical Care?		
Intestinal Disease?			Polio?			History of Fainting or Dizziness?		
Bone Disease?			Diabetes?			Presence of Drug / Alcohol Addiction?		
Endocrine Problems?			Anemia?			If Female: Are You Pregnant?		
HIV Positive?			Hemophilia?			Do You Smoke?		
Blood Transfusion?			Emphysema?			Have You Ever Had Fever Blisters?		
Tumors or Cancer?			Epilepsy or Seizures?			Are You in Good Health?		

If Female, Has Menopause Begun?	Yes	No
Are You Allergic to Anything?	Yes	No
If Yes, Please list all allergies. (penicillin, latex, medicines)		
Are You Currently Taking Any Medications?	Yes	No
If Yes, Please list all medications.		
Are You Aware of Any Other Disease, Condition, or Disability Not Listed Above?	Yes	No
If Yes, Please list/explain.		

Dental History

Patient's Dentist : Date Last Seen:		
Any Pain, Clicking or Discomfort In or Near the Ears? Yes / No Any Severe or Frequent Headaches?	Yes	No
Has Your Mouth, Face or Teeth Been Injured by a Fall or Accident?	Yes	No
Have You Been Informed of Missing or Extra Permanent Teeth?	Yes	No
Are You Aware of Any "Gum" Problems? Yes / No Have You Had Any Periodontal "Gum" Treatment?	Yes	No
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?	Yes	No
Have Your Tonsils or Adenoids Been Removed? Yes / No If Yes, When?		
Do You Feel You Can Benefit From Orthodontic Treatment?	Yes	No
Are You Happy with Your Smile? Yes / No Do You Want to Improve Your "Smile" and/or "Bite"?	Yes	No
Would You Mind Wearing "Braces"?	Yes	No
Have You Been Examined by an Orthodontist Before? Yes / No If Yes, When?		
Have Other Family Members Had Orthodontic Treatment? Yes / No If Yes, Were you happy with results? If Not, Why?		
What Is Your Chief Orthodontic Concern?		

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