Rodney J. Klima, D.D.S., P.C.
Adult Orthodontic Acquaintance Card

Date: _____ Date Of Birth: _____ Patient Age: _____
Month Day Year Month Day Year

Patient Name: _____ Name Patient Goes By: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Gender: M F

Home Address: _____
Street Address City State Zip

Referred By: _____ Have you seen another orthodontist? ☐ Yes ☐ No

Patient's Dentist: _____ Patient's Physician: _____

Patient's Occupation: _____ Employed By: _____

Business Phone: ( ) _____ Social Security Number _____

Spouse's Name: _____ Spouse's Occupation: _____

Spouse Employed By: _____ Spouse's Business Phone: ( ) _____

Person responsible for account: _____

Dental Insurance Carrier: _____ Orthodontic Coverage: ☐ Yes ☐ No ☐ Unsure

Policyholder Name: _____ Policyholder DOB: _____

General Appraisal

What concerns you most about your teeth? _____

Other relatives with similar orthodontic problems: ☐ Yes ☐ No Relationship _____

Has any member of your family received orthodontic treatment? ☐ Yes ☐ No

Will patient's cooperation be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Indifferent

Patient's attitude toward receiving orthodontic treatment: _____

Have we seen any other members of your family? ☐ Yes ☐ No Name: _____ Age: _____

Medical History

Is patient in good health? ☐ Yes ☐ No

Does the patient have any history of major illness? ☐ Yes ☐ No

Check any of the following for which the patient has been diagnosed or treated:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Bone Disorders
- ☐ Bleeding Abnormality
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis, Type:____
- ☐ High Blood Pressure
- ☐ Kidney Involvement
- ☐ Liver Involvement
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Other:

Does patient have a tendency toward: ☐ Colds? ☐ Sore Throats? ☐ Ear Infections?

Have tonsils and/or adenoids been removed? ☐ Yes ☐ No If yes, at what age? _____

List any drugs or medications now being taken by the patient with reason for taking it:

_____

List any allergies or drug sensitivity:

_____

Dental History

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No If Yes, explain: _____

Has the patient ever sucked a thumb or fingers? ☐ Yes ☐ No Until what age? _____

Does the patient have speech problems? ☐ Yes ☐ No If Yes, explain: _____

Is the patient a mouth breather? While Awake? ☐ Yes ☐ No While asleep? ☐ Yes ☐ No

Have you been informed the patient has any missing or extra teeth? ☐ Yes ☐ No

List any musical instruments the patient plays: _____

Email Address: _____ _____
(Print Clearly) **Signature of Patient**

Rev. 04/16