

RANDALL P. RIGSBY, D.M.D.

Welcome To Our Office

ADULT ORTHODONTIC ACQUAINTANCE CARD

DATE _____

—Please Print—

Date of Birth _____

Name _____ Age _____ Sex: Male Female

First Middle Last

Name Patient Prefers to be Called _____

Home Address _____ Telephone _____

Street City State Zip

Marital Status Married Divorced Single Soc Sec No _____

Occupation _____ Employer _____

Business Address _____ Business Telephone _____

Name of Spouse _____

Occupation _____ Employer _____

Business Address _____ Business Telephone _____

Name of Person Responsible for Account if Other Than Yourself _____

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

Name of Insurance Company _____

Dentist _____ Physician _____

Last Visit to Dentist _____

Whom may we thank for referring you? _____

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:

- | Yes/No | Yes/No | Yes/No | Yes/No |
|--|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> <input type="checkbox"/> Aids | <input type="checkbox"/> <input type="checkbox"/> Night Grinding of Teeth |
| <input type="checkbox"/> <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Jaw Joint Pain (TMJ) | <input type="checkbox"/> <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Facial Injury | |
| <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> Bone Disorders | |

List Any Medicines Now Being Taken. Give Reasons _____

List Any Allergies or Drug Sensitivities _____

DENTAL HISTORY

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

Have you ever had gum disease? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Have you had any previous orthodontic treatment? _____ Yes No

If so, by whom? _____

Has anyone in your family had orthodontic treatment? _____ Yes No

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 may be helpful _____

THANK YOU

Member



American Association of Orthodontists

Patient's Signature _____