tasios Orthodontics
Where Smiles Are Contagious

Adult Orthodontic Acquaintance Form

Patient's Name: _____ Today's Date: _____
Date of Birth: _____ (mm/dd/yy) Age: _____ Sex: M F Occupation: _____
Home Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Email: _____
Emergency Contact Name: _____ Phone: _____ Relation: _____

Reason for orthodontic consultation: _____
Who may we thank for referring you? _____

INSURANCE INFORMATION. Does the patient have orthodontic coverage? Yes No

Primary Policy Holder's Name: _____ Date of Birth: _____ (mm/dd/yy) Employer: _____
Insurance Provider: _____ Policy#: _____ Certificate/ID#: _____

Secondary Policy Holder's Name: _____ Date of Birth: _____ (mm/dd/yy) Employer: _____
Insurance Provider: _____ Policy#: _____ Certificate/ID#: _____

MEDICAL HISTORY. Have you been treated for any of the following (please circle):

Asthma	Thyroid	Osteoporosis	Artificial Joints	Arthritis
HIV/Aids	Sleep Apnea	Tuberculosis	Epilepsy/Seizures	Diabetes
Kidney Disorder	Blood Pressure	Heart Condition	Artificial Heart Valve	Liver Disease
Other (please specify) _____		Hepatitis A/B/C	Prolonged Bleeding	Heart Murmer

Patient's Physician Name and Phone #: _____
Do you require antibiotic premedication for dental procedures? _____
Are you currently take any prescription medications? _____
Do you have any allergies? Yes No If yes, please specify: _____

DENTAL HISTORY.

Patient's Dentist Name and Phone #: _____ Date of last dental check-up: _____ (mm/dd/yy)
Is there a history of any injuries to your mouth/teeth/face? Yes No If yes, please specify: _____
As a child, have you ever sucked your thumb? Yes No
Do you breathe through your mouth? Yes No
Have you been informed of any missing permanent teeth? Yes No
Have you ever had an orthodontic consultation before? Yes No
Have you previously had orthodontic treatment in the past? Yes No
Please list any sports, hobbies or musical instruments: _____

I hereby give Dr. Bruce Tasios and/or members of his staff permission to release information concerning my dental and/or orthodontic health to my family physician, dentist or any other dental specialist as deemed necessary to optimize my oral health. Such information includes radio-graphs and other diagnostic records which pertain to the condition, diagnosis, or proposed treatment.

We will provide the highest level of confidentiality with respect to the collection and disclosure of all your personal information that is provided to us.

I, the undersigned, certify that I have read and understood the above medical and dental information and have answered the questions in an accurate manner. If there are any changes to my medical history, I recognize that it is my responsibility to inform the office. I also give permission for Dr. Bruce Tasios to complete the clinical examination.

_____
Signature of Patient

_____
Date