IDALIA LASTRA, D.M.D.

ADULT ORTHODONTIC ACQUAINTANCE FORM

Welcome to our office! In order to best serve you, we need some information for our records. Please try to answer all the questions. Feel free to ask our staff for help if needed. Thanks!

Date_____

Patient's Name _____ Sex ____ S.S.# _____

First *Middle Initial* *Last*

Nickname _____ Age_____ Birthdate (month)_____ (day)_____(year)_____ Marital Status _____

Home Address_____ City _____State ___Zip _____ Home phone_____

Occupation _____ Employer _____Work phone_____

Business Address _____City _____ State____ Zip_____

Spouses' Name _____ Occupation_____ Children?_____

Send Statement to: Name _____ Relation:_____ S.S.# _____

Address _____ City_____ State____ Zip _____ Phone _____

Dentist _____ Last visit _____Who may we thank for telling you about our office? _____

Have you ever seen an Orthodontist before? _____ When?_____ Orthodontist's name?_____

Have you ever worn braces? _____Orthodontist _____ City _____ State ____ How long in treatment?_____

Are you covered by insurance for orthodontic treatment? _____Insurance Company_____

Why did you come to see us? _____

_____

What would you like to change about your teeth? _____

What do you feel may have caused these problems? _____

How do you feel about wearing braces? _____

Are there other family members with a similar orthodontic condition? _____

Has any other family member worn braces? _____ If so, whom? _____

Any oral habits? Finger sucking _____Tongue thrust_____ Pencil, nail or lip biting ____ Mouth breathing _____Grinding ____ Clenching _____

Temporomandibular joint symptoms? Headaches_____ Clicking ____ Locking ____ Pain_____Limited opening _____Dizziness____ Other____

Medical History Physician _____General Health_____

Any history of: Allergy _____ Arthritis _____ Asthma _____ Anemia_____ Blood Disease ____ Convulsions _____Congenital defects_____

Diabetes_____ Epilepsy _____ Glands (endocrine) _____Heart _____ Heart Murmur_____Hepatitis _____ Jaundice _____ Kidney_____

Liver_____ Lung Disease_____ Rheumatic Fever_____Sinus ____ Tuberculosis_____HIV ____ AIDS ____ Pregnancy? _____How long? _____

Do you have any disease, condition, or problem not listed above that we should know? _____

Any medications being taken?_____ Any operations?_____

Toothaches? _____ Fractured teeth? _____ Speech problems? _____ Bleeding Gums? _____

Any injuries to face, head, or teeth?_____Any bad dental experiences? _____

Hobbies/Special Interests _____

Signature _____