Orthodontic Acquaintance Form
Dara J. Chira D.M.D.

SECTION 1

Patient's Name _____ Preferred Name _____ Sex _____

Home Address _____ Date of Birth _____ Social Security No.: _____
STREET TOWN STATE ZIP

Home Phone _____ Name of Family Physician: _____

School (if patient is minor): _____ Grade: _____

SECTION 2

	A PARENT / ADULT /Self	B PARENT / SPOUSE/Partner
Name:		
Address (If different from above):		
Phone (If different from above):		
Social Security Number:		
Birthdate	Month: ____ Day: ____ Year: ____	Month: ____ Day: ____ Year: ____
Employer's Name:		
Business Phone:		
Occupation:		

Email:

Cell#:

Parent's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Person responsible for payment of account: _____ Address (If different from above) _____

Does the patient have an orthodontic benefit with Delta Dental? ☐ Yes ☐ No Name of Insurance Company: _____

SECTION 3

MEDICAL HISTORY

	YES	NO	
Is the Patient experiencing any health problems?	☐	☐	Reason: _____
Any major or unusual illnesses?	☐	☐	Explain: _____
Currently under physician's care?	☐	☐	Reason: _____
Currently taking medication?	☐	☐	List: _____
Allergies	☐	☐	List: _____
Drug sensitivity	☐	☐	List: _____
Has the patient ever received blood transfusion?	☐	☐	Reason: _____

Please Check If Patient Has or Had Any of the Following:

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Frequent Colds or Flu
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Tonsillitis
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Adenitis
☐	☐	Hepatitis	☐	☐	Endocrine (Hormone) Problems	☐	☐	Tonsils Removed: Age: _____
☐	☐	Been in a risk group for AIDS?	☐	☐	Bone Disorders	☐	☐	Adenoids Removed: Age: _____
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes	☐	☐	Mouthbreathing: While awake? _____
☐	☐	Heart Murmur				☐	☐	While asleep? _____

SECTION 4

Growth Information for Patients Under 16 Years of Age

Father's Height: _____ Mother's Height: _____ Adopted? ☐ No ☐ Yes

Patient Resembles: ☐ Neither Parent ☐ Mother ☐ Father

Girls: Has she started menstruation? ☐ No ☐ Yes When? _____

Boys: Has his voice changed? ☐ No ☐ Yes When? _____

Name and Ages of Patient's Brothers and Sisters: _____

Have they had Orthodontic Treatment? ☐ No ☐ Yes When? _____

Patient's Growth

Date ____ Height ____ Weight ____

Date ____ Height ____ Weight ____

Date ____ Height ____ Weight ____

SECTION 5

DENTAL HISTORY

Name of local dentist patient sees for cavity checkups/restorative dentistry _____

YES	NO	
☐	☐	Has the patient had any severe head or face injuries? Explain: _____
☐	☐	Has the patient had a history of thumb sucking or finger sucking? Stopped? _____
☐	☐	Does the patient play any musical (wind) instruments? What: _____
☐	☐	Has the patient consulted an orthodontist previously?
☐	☐	Has the patient had any previous orthodontic treatment? With whom? _____
		Are you satisfied with the prior treatment? _____

PLEASE CHECK IF THERE IS A HISTORY OF:

☐ Clenching Teeth ☐ Muscular Soreness around Head and Neck ☐ Jaw Joint Soreness ☐ Jaw Joint Popping

☐ Grinding Teeth ☐ Headaches (more than normal) ☐ Jaw Joint Clicking ☐ Ringing in the Ears

Is there any other information that may be helpful? _____

Why are you seeking an orthodontic consultation? _____

THANK YOU _____ Signature _____ Date

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TEMPOROMANDIBULAR JOINT QUESTIONAIRE

Name: _____ Age: ____ Sex: ____ Date: _____

Please answer all questions.

1. Do you have clicking, popping or grating noise in your
   Right jaw joint? YES NO
   Left jaw joint? YES NO
2. When did you first notice the noise? _____
3. Has the noise recently become more pronounced? YES NO
   When? _____
4. Do you have pain in or around the right joint? YES NO
   Left joint? YES NO
5. When did you first notice the pain? _____
6. Has the pain recently become more pronounced? YES NO
   When? _____
7. Is the pain worse: Mornings _____ At meals _____
   Evenings _____ No specific time _____
8. Is this pain: Dull _____ Continuous _____
   Stabbing _____ Intermittent _____
   Throbbing _____ Other _____
9. Does the pain sometimes feel like it is in your ear? YES NO
10. Do you think this problem has affected your hearing? YES NO
11. Does your jaw problem interfere with your normal activities? YES NO
12. Are you taking or have you taken medication for this problem? YES NO
    Explain _____
13. Did anything occur which might be related to the onset of this problem? YES NO
    Explain _____
14. Do you have difficulty chewing? YES NO
    Because of: Pain in joint _____ Limited opening _____
    Pain in teeth _____ Missing teeth _____
    Clicking _____ Other _____
15. Has your mouth ever locked open so you were unable to close it? YES NO
    Explain _____
16. Have you had problems opening your mouth wide? YES NO
    Explain _____
17. Please indicate the time sequence in which you became aware of the following problems (1st, 2nd, 3rd, etc.) Number only those which apply to you.
    Pain _____ Noise _____ Limited opening _____ Locking _____ Other _____
18. Which aspects of your problem concern you the most?
    _____
19. Are you aware of clenching your teeth? YES NO
20. Do you grind your teeth? YES NO
    When? _____
21. Has there been a recent change in your lifestyle such as a change in marital status, childbirth, change of employment, death in immediate family or other stressful events? YES NO
22. Do you think nervous tension seems to affect this problem? YES NO
    Explain _____
23. Have you had problems with other joints? YES NO
24. Have you had orthodontic treatment? YES NO
    When _____ Where _____
25. Have you had recent dental treatment? YES NO
    Explain _____
26. Have you had x-rays taken for this problem? YES NO
    When _____ Where _____
27. Have you received previous treatment for this problem? YES NO

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PATIENT MOTIVATION FOR TREATMENT

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us understand your problem by checking the following information; please be specific (circle the words *more, less, forward, backward, longer, shorter,* etc.)

1. **THE TEETH**

If your teeth could be changed, how would like them to change?

[ ] straighten the front teeth upper / lower
[ ] straighten the back teeth upper / lower
[ ] make the upper front teeth longer / shorter
[ ] move upper teeth forward / backward
[ ] move lower teeth forward / backward
[ ] make the line of the upper front teeth more level
[ ] other:

2. **THE FACE**

If your facial appearance could be changed, what would you change?

[ ] get rid of the sag under the lower jaw
[ ] move chin forward / backward
[ ] move chin left / right / to center it
[ ] move lower lip forward / backward
[ ] move upper lip forward / backward
[ ] move the area around the nose forward / backward
[ ] make the profile of my nose longer / shorter
[ ] move the area under my eyes forward / backward
[ ] make the cheekbones larger / smaller
[ ] show more / less of my teeth / gums when I smile
[ ] make my lips closer together / farther apart when my teeth are touching
[ ] make my lips not touch and roll out when my teeth are touching
[ ] reduce the strain in my chin / lips when I close my lips
[ ] make my face more narrow / wide
[ ] reduce the width / fullness of my lower jaw behind my mouth
[ ] other:

3. **SYMPTOMS**

If you want to reduce pain or discomfort where would it be located? Please be specific about the location.

[ ] in front of my ears right / left / both sides
[ ] below my ears right / left / both sides
[ ] above my ears right / left / both sides
[ ] in my ears right / left / both sides
[ ] neck right / left / both sides
[ ] shoulders right / left / both sides
[ ] temples right / left / both sides
[ ] teeth
[ ] sinuses
[ ] eyes right / left / both sides
[ ] other:

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Welcome to our practice! Because we value your time, we'd like to share some information with you regarding our appointment and insurance guidelines.

Appointment Policy

We understand that our office is not the only stop on your list of important places to be in a day, and we'll do our best to honor your schedule. Our office hours are Monday-Thursday from 8:30 am until 5:00 pm.

Because we take measures to respect your time, we ask that you do the same for us and our other patients. **Please give at least 48 hours notice if you need to reschedule or cancel an appointment, to allow us time to offer this appointment to another patient. If you miss an appointment or provide less than 48 hours notice, there may be a minimum broken appointment charge of $50 for every half hour increment.** You contact us either by phone or email and we'd happy to reschedule your appointment.

We understand that last-minute illnesses or emergencies occur, and we respond in kind if you need to cancel or reschedule an appointment.

Insurance Policy

We are a provider for Delta Dental Insurance. We are able to submit claims only to Delta Dental Companies. Delta Dental will send payment directly to us for treatment. If you have dental coverage through another plan, we will provide you with a claim form that you can submit to your insurance company. The insurance company will then reimburse you if a benefit is due to you according to your policy.

You as the patient or parent, are ultimately responsible for any fees incurred at our practice. We are happy to work with you to maximize your orthodontic benefit and can provide you with a statement if you need one. **Please be aware that most insurance companies do not cover the initial exam or diagnostic records, so fees for these appointments are your responsibility.**

Thank you for reading and understanding our Appointment and Insurance Policies.

_____

Print Patient's Name

_____

Signature of Patient or Parent/Legal Guardian Date

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