John M. Wirant, D.M.D.
ORTHODONTICS

AA

ORTHODONTIC ACQUAINTANCE FORM

Patient's Name:	Date:
Last First M.I.	Date Of Birth:
Home Address:	Sex:
	Home phone:
Occupation:	Cell:
Employed By:	SS#:
Business Address:	
Spouse's Name:	
Occupation:	Cell:
Employed By:	
Business Address:	
Names and Ages of children in family:	
Email address for appointment reminders:	

Medical History

John M. Wirant, D.M.D.

Name of your physician:

Are you in good health? ☐ Yes ☐ No

Have you ever been hospitalized, had general anesthesia of emergency room visits? ☐ Yes ☐ No ☐ Don't Know

If yes, please explain:

Allergies (please list):

Past medications taken by you:

Daily medications you are is now taking:

Has you ever had or been treated by a physician for:

☐ Problems at birth	☐ Tuberculosis	☐ Cleft lip/palate	☐ Heart murmur	☐ Liver disease
☐ Speech/Hearing problems	☐ Eye problems	☐ Heart disease	☐ Kidney disease	☐ Rheumatic fever
☐ Diabetes	☐ Skin problems	☐ Anemia	☐ Arthritis	☐ Tonsil/Adenoid problems
☐ Bleeding/hemophilia	☐ Cancer	☐ Sleep problems	☐ Blood Transfusion	☐ Cerebral palsy
☐ Anxiety	☐ Hepititis	☐ Seizures	☐ AIDS/HIV	☐ Asthma

Other Please list:

Height ☐ Weight ☐

Dental History

What is your main concern about your dental condition?

Last dental exam date:

Name of your dentist: City/Town

Yes ☐ No ☐ ?? ☐	Have you had dental x-rays? Date of last x-rays:
Yes ☐ No ☐ ?? ☐	Have you experienced any complications following dental treatment? If yes, please explain:
Yes ☐ No ☐ ?? ☐	Do you have cavities (not treated) or toothaches? If yes, please explain:
Yes ☐ No ☐ ?? ☐	Are your teeth sensitve to temperature, pressure or certain foods?
Yes ☐ No ☐ ?? ☐	Have you ever received instruction on proper tooth brushing technique?
Yes ☐ No ☐ ?? ☐	Do your gums bleed when brushed?
Yes ☐ No ☐ ?? ☐	Have you had any clicking or pain in his/her jaw joints? If yes , please explain:
☐ ☐ ☐	
Yes ☐ No ☐ ?? ☐	Have inherited any family facial of dental characteriseristics? If yes, please explain:
Yes ☐ No ☐ ?? ☐	Are you a mouth breather? ☐ While Awake? ☐ While Asleep?
Yes ☐ No ☐ ?? ☐	Have you ever injured his/her teeth?
Yes ☐ No ☐ ?? ☐	Have you ever injured your jaw or face?
Yes ☐ No ☐ ?? ☐	Have you been informed of any missing or permanent teeth?
Yes ☐ No ☐ ?? ☐	Has another orthodontist been consulted previously?
Yes ☐ No ☐ ?? ☐	List any musical instruments played:

Do you have any other dental problems we should know about? ☐ Yes ☐ No Please explain:

How did you hear about us?

Whom may we thank for referring you to our office?

How else did you hear about us? Check all that apply.

☐ Mailer/postcard ☐ Sign ☐ Website ☐ Google search ☐ Insurance

☐ Doctor's office ☐ Event ☐ Facebook ☐ Other:

PERSON COMPLETING THIS FORM:

Signature: