David L. Sparks, D.D.S.
ORTHODONTIST

CALIFORNIA
TIN GRIN

ADULT ORTHODONTIC ACQUAINTANCE CARD

Date_____20_____ Date of Birth_____
Patient's Name_____ Age _____Sex _____ Spouse _____
Address _____ Home Phone ( )_____
City_____ Zip _____How long at this address? _____ Cell Phone ( )_____
Patient's Dentist_____ Phone( )_____City _____
Who may we thank for sending you to us ?_____
Your SS#_____ Spouse SS# _____
Your Employer _____ Spouse Employer _____
Your Bus. Phone _____Ext_____ Spouse Bus. Phone ( ) _____Ext._____
Your Ins. Co._____ Spouse Ins. Co. _____Birthday_____
Your Ins. Co. Phone ( )_____ Spouse Ins. Co. Phone ( )_____
Person Responsible for Account _____ Phone ( ) _____
Email Address_____

In the following questions, circle yes or no, whichever applies:

1. Are you in good health ? ..... YES NO
2. Has there been any change in your general health within the past year ?..... YES NO
3. My last physical examination was on _____
4. Are you now under the care of a physician ? ..... YES NO
5. The name of my physician _____
   address _____
   city & phone _____
6. Have you been hospitalized or had a serious illness within the past (5) years ? (please explain)..... YES NO
   a. Rheumatic fever or rheumatic heart disease ..... YES NO
   b. Congenital heart lesions ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... YES NO
      1. Do you have pain in your chest upon exertion ? ..... YES NO
      2. Are you ever short of breath after mild exercise ? ..... YES NO
      3. Do your ankles swell ? ..... YES NO
      4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep ?.. YES NO
      5. Do you have a cardiac pacemaker ? ..... YES NO
   d. Sinus trouble ..... YES NO
   e. Asthma or hay fever ..... YES NO
   f. Hives or skin rash ..... YES NO
   g. Fainting spells, seizures or epilepsy (Please Circle) ..... YES NO
   h. Diabetes ..... YES NO
      1. Do you have to urinate more than six times a day ? ..... YES NO
      2. Are you thirsty most of the time ? ..... YES NO
      3. Does your mouth become frequently dry ? ..... YES NO
   i. Jaundice, liver disease, hepatitis, or a carrier of hepatitis ? (Please Circle) ..... YES NO
   J. Arthritis ..... YES NO
   k. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   l. Stomach ulcer..... YES NO
   m. Kidney trouble ..... YES NO
   n. Tuberculosis ..... YES NO
   o. Do you have a persistent cough or cough up blood ? ..... YES NO

(over)

p. Low blood pressure..... YES NO
q. Venereal disease (Specify)..... YES NO
r . HIV or ARC (Specify)..... YES NO

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma ?..... YES NO
   a. Do you bruise easily ?..... YES NO
   b. Have you ever required a blood transfusion?..... YES NO
   If so, explain circumstances _____
8. Do you have any blood disorder, such as anemia?..... YES NO
9. Have you had surgery or X-ray treatment for a tumor, growth, or other conditions of the head or neck?..... YES NO
10. Are you taking any drug or medicine?..... YES NO
    If so , what? _____
11. Are you allergic or have you reacted adversely to:?
    a. Local anesthetics..... YES NO
    b. Penicillin or other antibiotics (Specify)_____ YES NO
    c. Sulfa drugs..... YES NO
    d. Latex..... YES NO
    e. Aspirin..... YES NO
    f . Codeine or other narcotics (Specify) _____ YES NO
    g. Other (Specify) _____ YES NO
12. Have you had any serious trouble associated with any previous dental treatment?..... YES NO
    If so, explain_____
13. Do you require antibiotics before dental procedures?..... YES NO
14. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?..... YES NO
    If so explain _____
15. Have your tonsil and adenoids been removed? At what age? _____..... YES NO
16. Women - are you pregnant at the present time? How many months? _____..... YES NO
17. Is there any medical condition or serious illness, past or present that we should know about?..... YES NO
    a. If yes, explain _____

DENTAL HISTORY

1. Has there been any injuries to the face, mouth, or teeth ?..... YES NO
2. Does your jaw ever hurt ?..... YES NO
3. Does your jaw ever pop or crack when opening ?..... YES NO
4. Has your jaw ever locked open or closed ?..... YES NO
5. Do you have any speech problems ? ..... YES NO
6. Are you a mouth breather ? ..... YES NO
7. Has an orthodontist been consulted previously? Who ?_____..... YES NO
8. Has any family member had orthodontic treatment ? ..... YES NO
9. When was the last dental care ?_____
10. What do you want orthodontic treatment to accomplish ? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____
Signature Date

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____ _____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

(_____)
Dr.