Sophie Markovich, DMD, P.C.
Family Orthodontics

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WELCOME TO OUR OFFICE

In order for us to provide you with optimum care, your cooperation is needed in providing us with all the necessary information. Please answer all of the questions below in as much detail as possible. All information is held in strict confidence.

Today's date____________ E-mail

Your Name:____ Female/Male________
Preferred Name (Nickname):______________________ Family Dentist:____________________
Age________Date of Birth____________________________Home Phone ( )____________
Address:____
City:________________________State:___________________Zip:___________________
Employed By:____
Business Address:______________________________________Business Phone:( )__________
Spouse's Name:____Home Phone: ( )__________
Address:____
City:____________________________State:_______________Zip:____________________
Employed By:____
Business Address:____Business Phone:( )________
Please list any other family members whom we've seen in our office:
Name____Age______________
Name____Age______________

Yes_____ No_____ Are you in good health?
Yes_____ No_____ Do you have any history of major illness?
Yes_____ No_____ Have you been under the care of a physician for an illness in the past 2 years?
If so, please describe with dates, and physician names:_____________________
____
____

Whom may we thank for referring you to our office?
If you were referred by your dentist, why did your dentist feel that it was advisable for you to obtain an orthodontic evaluation?____
____

Check any of the following for which you have been treated or now have:

___Aids/HIV	___Cancer	___Hearing Disorders	___Lung Dis./TB
___Allergies/Asthma	___Diabetes	___Heart Disease	___Osteoporosis
___Arteriosclerosis	___Endocrine Disorder	___Hepatitis	___Pregnancy
___Arthritis	___Epilepsy	___High/Low Blood Pressure	___Psychologic/Psych Care
___Blood Disease	___Fainting/Dizziness	___Kidney Disease	___Rheumatic Fever
___Bone Disorders	___Head,Face Injury	___Liver Disease	

OVER ☞

If applicable, please write the name, dosage, and purpose of all prescription drugs that you are taking and please identify any allergies:

Prescription Drug	Allergies
______________________	______________________
______________________	______________________
______________________	

Have you had your tonsils and/or adenoids removed? If so, which?____________

Have you had **any** tooth sensitivity to hot, cold or biting pressures?____________

Have you noticed **any** changes in your bite over the past several years?____________

Is your bite comfortable?____________

Have you noticed any shifting of the teeth in the past two or three years? If so, please describe:____________

____

Have you been told, or are you aware of grinding your teeth at night? If so, please describe:____________

____

Has there been breakage of fillings, crowns or enamel?____________

Have you had any pain, clicking, popping or locking in the jaw joints? If so, please describe:____________

____

____

What is your primary concern in seeking an orthodontic evaluation?____________

____

What questions do you hope to have answered at today's initial evaluations appointment?

1.____________

2.____________

3.____________

INSURANCE: Dental Insurance Yes ☐ No ☐ Orthodontic Insurance Yes ☐ No ☐
Insured:____________ ID #____/____/____ Group #____________
Employer:____________
Insurance Company:____________ Insurance Co. Phone____________
Insurance Company Address:____________
____

The above questions have been fully and accurately answered to the best of my knowledge. I will keep the office informed of any changes in medical condition. I authorize treatment for the patient named above and agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature____________ Date____________
Relationship to Patient____________

Thank you for thoughtfully completing this acquaintance form!