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!