

**CONFIDENTIAL**

**Member  
American Association of  
Orthodontists**

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*Specialist in Orthodontics*

**GET ACQUAINTED QUESTIONNAIRE**

**ADULT**

*The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.*

Patients full name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_ Height \_\_\_\_\_ ' \_\_\_\_\_ " Weight \_\_\_\_\_  
Musical Instrument Played \_\_\_\_\_  
Favorite Sports, Hobbies, & Avocations \_\_\_\_\_  
Whom may we thank for referring you to this office? \_\_\_\_\_

**IN CASE WE CANNOT REACH YOU:**

Person to contact \_\_\_\_\_ Phone No. \_\_\_\_\_

**ORTHODONTIC INSURANCE COVERAGE:** yes  no

Primary Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Secondary Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_

**FAMILY INFORMATION**

Patients Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone No. \_\_\_\_\_ Cell / Work no. \_\_\_\_\_  
How long? \_\_\_\_\_ Anticipate Moving? \_\_\_\_\_ When and Where \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business Phone \_\_\_\_\_ Address \_\_\_\_\_  
Spouse's Name (if applicable) \_\_\_\_\_  
How many brothers \_\_\_\_\_ Ages \_\_\_\_\_ Sisters \_\_\_\_\_ Ages \_\_\_\_\_  
Do they have any orthodontic problems? \_\_\_\_\_  
Have they had any orthodontic treatment? \_\_\_\_\_  
Natural parents: yes  no   
Does father have normal teeth? \_\_\_\_\_ Father treated? \_\_\_\_\_  
Does mother have normal teeth? \_\_\_\_\_ Mother treated? \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

*We want to thank you for your cooperation in supplying the above information.*

**PATIENT INFORMATION**