TIMOTHY SHAUGHNESSY, D.D.S., M.S.

Welcome To Our Office

ADULT ORTHODONTIC ACQUAINTANCE CARD DATE_____

Please Print-

Email_____ Date of Birth_____

Name_____ Age_____ Sex: Male ☐ Female ☐

First Middle Last

Name Patient Prefers To Be Called_____ Cellphone_____

Address_____ Telephone_____

Street City State Zip

Marital Status: Married ☐ Single ☐ Divorced ☐ Soc. Sec. No._____

Occupation_____ Employer_____

Business Address_____ Telephone_____

Name of Spouse_____

Occupation_____ Employer_____

Business Address_____ Telephone_____

Name Of Person Responsible For Account If Other Than Yourself_____

Do you have dental insurance that covers orthodontic treatment? Yes ☐ No ☐

Name Of Insurance Company_____ Claims Address & Phone_____

Subscriber's Name_____ Subscriber's DOB_____ Group #_____ ID#_____

Dentist_____ Physician_____

Last Visit To Dentist _____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Are you in good health? Yes ☐ No ☐ History Of Major Illness? Yes ☐ No ☐

Are you presently under the care of a physician for a specific problem? Yes ☐ No ☐

If so, explain_____

_____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ Liver Disease	☐ Epilepsy	☐ Facial Injury
☐ Glaucoma	☐ High Blood Pressure	☐ Bleeding Problems	☐ Bone Disorders
☐ Heart Trouble	☐ Allergies or Asthma	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Rheumatic Fever	☐ Jaw Joint Pain (TMJ)	☐ Night Grinding of Teeth
☐ Hepatitis	☐ Venereal Disease	☐ Arthritis	☐ Emotional Problems

List Any Medicines Now Being Taken Give Reasons_____

List Any Allergies or Drug Sensitivities_____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth?_____ Yes ☐ No ☐

Have you ever had gum disease?_____ Yes ☐ No ☐

Have you been informed of any missing or extra permanent teeth?_____ Yes ☐ No ☐

Has an orthodontist been consulted previously? _____ Yes ☐ No ☐

Have you had any previous orthodontic treatment?_____ Yes ☐ No ☐

If so, by whom? _____

Has anyone in your family had orthodontic treatment?_____ Yes ☐ No ☐

Do you have an unusual amount of stress in your life?_____ Yes ☐ No ☐

Reason for seeking orthodontic treatment (What problem do you wish to have corrected?)_____

_____

Please list any additional information which you feel may be helpful_____

_____

THANK YOU

Member
American Association of
Orthodontists

_____
Patient's Signature