John E. Ogro, D.D.S. **Orthodontic Acquaintance Form**

PATIENT INFORMATION:
Name: _____
Street: _____
City, State Zip_____
Birthdate: _____
Dentist: _____
Referred by : _____

BILLING INFORMATION:
Name: _____
Street: _____
City, State Zip _____
Phone: _____
Mobile: _____
Email: _____

DENTAL INSURANCE INFORMATION

Insured's Full Name_____ **Insured's Date of Birth**_____
Insured's Social Security # or ID#_____
Patient's Full Name_____
Insured's Employer _____
DENTAL INS. CARRIER_____Group No. _____Tele No. _____
Address _____
Street City State Zip

MEDICAL HISTORY:

Have you ever taken a bisphosphonate for bone loss related issues? yes___ no___
Do you have any history of major illness? yes___ no___
If so, please describe _____
Do you require premedication prior to dental visits? yes___ no___
Do you have any drug sensitivities or allergic reactions? yes___ no___
If so, please list _____
Are you presently taking any medication? yes___ no___
If yes, please list _____
Are you under medical care now, other than routine? yes___ no___
Physician's name _____ Phone # _____
Please check any of the following for which you have been treated:

___ Diabetes	___ Asthma	___ Prolonged Bleeding
___ Arthritis	___ Epilepsy	___ Nervous Disorders
___ Heart Trouble/Murmur	___ Rheumatic Fever	___ Hepatitis
___ AIDS/ARC	___ Sleep Apnea	___ Tuberculosis

DENTAL HISTORY:

Have you suffered any severe injury to the face? yes___ no___
Are you aware of any missing permanent teeth? yes___ no___
Do you clench or grind your teeth? yes___ no___
Do you have pain or clicking upon closing? yes___ no___
Have you had any previous orthodontic treatment? yes___ no___
When did you last visit your dentist?_____

COMMENTS:

_____

_____

Please be sure to bring this form with you for the examination appointment. **Thanks!**

_____ _____
Signature Date