Orthodontic Acquaintance Form

Date__________________

Patient Name____

Address____

Home Phone #____________________________________Cell #_____________________________________

Date of Birth__________________________School_____________________________Grade_______________

Patient's Dentist____

Physician____

Whom can we thank for referring you to our office? ____

Father's Name____ Soc. Sec. #______________________

Occupation____

Employed by____

Business address____

Business Phone #__________________________________ Email___________________________________

Mother's Name____ Soc. Sec. #______________________

Occupation____

Employed by____

Business address____

Business Phone # __________________________________ Email___________________________________

Person responsible for financial obligations____

Do you have orthodontic insurance? _____________ Dental insurance? ________________________________

Insurance company____

Names and ages of other children in family____

MEDICAL HISTORY

Is patient in good health? ❑Yes ❑No

Have you ever been hospitalized for a serious illness? ❑Yes ❑No

If yes, please explain: ____

Have you ever had any of the following?

Tire easily; Weakness	❑Yes	❑No	Persistent fever	❑Yes	❑No
Marked weight change	❑Yes	❑No	Blood transfusion	❑Yes	❑No
Night sweats	❑Yes	❑No			

Please check any of the following for which the patient has been treated or diagnosed:

Diabetes	❑Y ❑N	Heart trouble	❑Y ❑N	Prolonged bleeding	❑Y ❑N
Pneumonia	❑Y ❑N	Rheumatic fever	❑Y ❑N	Fainting/dizziness	❑Y ❑N
Tuberculosis	❑Y ❑N	Bone disorders	❑Y ❑N	Nervous disorders	❑Y ❑N
Anemia	❑Y ❑N	Venereal disease	❑Y ❑N	Liver problems	❑Y ❑N
Epilepsy	❑Y ❑N	Kidney problems	❑Y ❑N	Psychological problems	❑Y ❑N
Asthma	❑Y ❑N	Endocrine problems	❑Y ❑N	Developmental disability	❑Y ❑N
HIV+	❑Y ❑N	Immunosuppression	❑Y ❑N		

Is there any disease, condition, or problem not listed above that you think we should know about?

If yes, please explain:____

Do you have tendency to colds, sore throats, ear infections? ❑Yes ❑No

Have tonsils and adenoids been removed? ❑Yes ❑No

If yes, at what age? ____

List any drugs or medications now being taken, and give reasons:

____

List any allergies or drug sensitivity____

Has the patient reached puberty? Girls – started menstruation? ❑Y ❑N Boys – voice changed? ❑Y ❑N

Patient height_____________________________Weight_________________________________

Adolescent women: Are you pregnant now or think you may be? ❑Yes ❑No

DENTAL HISTORY

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

If yes, please describe: ____

Does the patient clench or grind their teeth? ❑Yes ❑No

Has the patient ever had any of the following?

Clicking/popping jaw? ❑Yes ❑No Difficulty opening/closing jaw? ❑Yes ❑No

Has the patient ever sucked a thumb or fingers? ❑Yes ❑No Until what age?________________

Does the patient have any speech problems? ❑Yes ❑No

Is the patient a mouth breather? ❑Yes ❑No While awake? ❑Yes ❑No While asleep? ❑Yes ❑No

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

Has an orthodontist been consulted previously? ❑Yes ❑No

Has either parent had orthodontic treatment? ❑Yes ❑No

List any musical instruments played____

Reason for consultation____

Patient Signature____