



ORTHODONTIC ACQUAINTANCE FORM

Date _____

Patient's Name _____ Birthdate _____ Sex _____

Res. Address _____ Telephone _____

_____ ZIP _____

School _____ Grade _____ SS# _____

Father's Name _____ Occupation _____

Employed by: _____ Business Tel: _____

Business Address: _____ ZIP _____

Mother's Name _____ Occupation _____

Employed by: _____ Business Tel: _____

Business Address: _____ ZIP _____

Who does the child reside with: Mother Father Both Parents Other _____

Address of non-custodial parent (if applicable): _____

Names & ages of other children in family _____

E-Mail address for appointment reminders _____

MEDICAL HISTORY

Name of your child's physician: _____

Is your child in good health? Yes No

Has your child ever been hospitalized, had general anesthesia or
Emergency room visits? Yes No Don't Know

If yes, please explain: _____

Are your child's immunizations up to date? Yes No Don't Know

Allergies (please list): _____

Past medications taken by child: _____

Daily medications child is now taking: _____

Has your child ever had or been treated by a physician for:

- | | | |
|--|---|--|
| Problems at birth <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Cleft lip/palate <input type="checkbox"/> |
| Heart murmur <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | Speech or hearing problems <input type="checkbox"/> |
| Heart disease <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | Eye problems <input type="checkbox"/> |
| Rheumatic fever <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Skin problems <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | Arthritis <input type="checkbox"/> | Tonsil/adenoid problems <input type="checkbox"/> |
| Bleeding/hemophilia <input type="checkbox"/> | Cancer <input type="checkbox"/> | Sleep problems <input type="checkbox"/> |
| Blood transfusion <input type="checkbox"/> | Cerebral palsy <input type="checkbox"/> | Emotional/behavior problems <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | Seizures <input type="checkbox"/> | Other Please list: _____ |
| AIDS or HIV <input type="checkbox"/> | Asthma <input type="checkbox"/> | _____ |

GIRLS - started menstruation BOYS - voice changed Yes No

Height _____ Weight _____

Do you consider your child to be (check one): Advanced In learning Progressing normally Slow learner

(other side)>>>>>

DENTAL HISTORY

What is your main concern about your child's dental condition? _____

Name of your child's dentist: _____

City/Town _____ Phone Number _____

Yes No ?? Has your child ever had dental x-rays? Date of last x-rays: _____

Yes No ?? Will your child be uncooperative? If yes, please explain: _____

Yes No ?? Has your child experienced any complications following dental treatment? If yes, please explain: _____

Yes No ?? Has your child had cavities and/or toothaches?

Yes No ?? Are your child's teeth sensitive to temperature, pressure or certain foods?

Yes No ?? Have you or your child ever received instruction on proper tooth brushing technique?

Yes No ?? Do your child's gums bleed when brushed? _____

Yes No ?? Does your child use fluoride products, rinses, drops, or tabs?

Yes No ?? Has your child had any clicking or pain in his/her jaw joints? If yes, please explain: _____

Yes No ?? Has your child inherited any family facial or dental characteristics? If yes, please explain: _____

Yes No ?? Is the child a mouth breather? While Awake? While asleep?

Yes No ?? Has your child ever injured his/her teeth? _____

Yes No ?? Has your child ever injured his/her jaw or face? _____

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

Yes No ?? Did your child use a pacifier? _____

Yes No ?? Did your child suck his/her finger or thumb? Until what age? _____

Yes No ?? Has an orthodontist been consulted previously?

Yes No ?? Has either parent had orthodontic treatment? _____

Yes No ?? List any musical instruments played: _____

Does your child have any other dental problems we should know about? Yes No Please explain: _____

Whom may we thank for referring you to our office? _____

How else did you hear about us? Check all that apply.

Phone Book

Sign/Banner

Website

Mailer/Magnet

Doctor's Office

Other _____

PERSON COMPLETING THIS FORM: Signature _____

Relationship to patient _____

Please do not forget to fill out a HIPAA privacy form. If you did not receive one, ask for one now.