ORTHODONTIC ACQUAINTANCE CARD

Patient #____________________ Date__________________________

Patient's name____Age_________Birthdate___________________Sex__________

Last First Middle Nickname

Address____Telephone (_____)____________________

Street City State Zip

Cell (_____)______________________

Whom may we thank for referring you to our office? (1)____(2)_______________________________________

Patient's dentist________________________________ Last Visit________________________Physician____

School____Grade___________________Attendance Excellent ☐ Good ☐ Fair ☐

Patient's interests and hobbies____________________________________ Purpose of this appointment____

PERSONAL HISTORY

E-mail____

Person financially responsible for this treatment____SSN_________________________DOB_______________

Address____City & State________________________________Zip_____________How long?________

Father's name___________________________Address______________________________________City & State__________________________Zip________

Single ☐ Married ☐ Divorced ☐ Widowed ☐ E-mail_______________________________ SSN_______________________DOB_______________

Employed by____How long?______ Occupation____

Business address____Telephone(____)_____________Cell(____)__________________

Mother's name___________________________Address______________________________________City & State__________________________Zip________

Single ☐ Married ☐ Divorced ☐ Widowed ☐ E-mail_______________________________ SSN_______________________DOB_______________

Employed by____How long?______ Occupation____

Business address____Telephone(____)_____________Cell(____)__________________

Do you have insurance that may cover part of our professional services? Yes ☐ No ☐ Company____

I understand that where appropriate, credit bureau reports may be obtained. Yes ☐ No ☐

MEDICAL HISTORY

Please check any of the following conditions or problems that you have experienced:

☐ Anemia	☐ Diabetes	☐ Excessive Bleeding	☐ Kidney
☐ Arthritis	☐ Emotional Disorder	☐ Eyes	☐ Liver (Hepatitis)
☐ Asthma	☐ Endocrine (Hormone)	☐ Hearing	☐ Rheumatic Fever
☐ Bone (fracture)	☐ Epilepsy or Fainting	☐ Heart	☐ Other

Have you ever been informed by a physician that you carry or have been exposed to a virus (i.e. Hepatitis, AIDS, Herpes, or other immuno-suppressive disorder)? Yes ☐ No ☐ ____

Does the patient have any physical or mental disabilities that we need to consider? Yes ☐ No ☐ ____

Have tonsils and adenoids been removed? Yes ☐ No ☐ If so, what age? ____

List any drugs or medications now being taken:___________________________________Give reasons:_______________________________________

List any allergies or drug sensitivities (i.e. aspirin, penicillin, novicaine, etc.)____

To evaluate growth: Has the patient reached puberty? Yes ☐ No ☐ Age_______ Pt. height_________Father's height_________Mother's height______

DENTAL HISTORY

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

Has the patient ever sucked a thumb or fingers? Until what age?____ Yes ☐ No ☐

Does the patient have any speech problems?____ Yes ☐ No ☐

Is the patient a mouth breather? While awake?__________________ While asleep?___________________________________ Yes ☐ No ☐

Has an orthodontist been consulted previously? Whom?__________________Where?_________________When?____________ Yes ☐ No ☐

Has either parent had orthodontic treatment? Whom?________________When?_____________Extractions?______________ Yes ☐ No ☐

Has a sibling had orthodontic treatment? Whom?_________________When?________________Extractions?______________ Yes ☐ No ☐

Does the patient's face resemble: Father?__________Mother?____________Other?____________Adopted?________________

Does the patient ever have any clicking/popping or pain upon opening or closing the mouth (TMJ disorder)? ______________ Yes ☐ No ☐

Names and ages of other children in family: ____

I authorize this office to obtain from or disclose information to my insurance company, family dentist, other specialist, and/or my medical doctor.

Signature of Parent or Guardian:____