Orthodontic Acquaintance • PERSONAL INFORMATION

Date Today: _____

Patient's Name: _____ Preferred Name: _____ Sex: _____

Home Address: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Name of Family Physician: _____

Whom can we thank for referring you to this office? _____

If transfer: _____
PREVIOUS ORTHODONTIST ADDRESS PHONE

Information for MINOR Patients:

School _____ Grade _____

Interests: _____

What is the child's attitude toward: Brushing: _____ Dentistry: _____ Orthodontics: _____

	FATHER	MOTHER
Name:		
Social Security Number:		
Date of Birth:		
Address & Phone No. (if different from above):		
Place of Business:		
Business and/or Mobile Phone Number:		
Occupation:		

Parents' Marital Status: ❒ Married ❒ Separated ❒ Widowed ❒ Divorced If divorced, who has custody of child?

MEDICAL HISTORY

Is the patient in good health?	❒ Yes	❒ No	Reason:
Any major or unusual illnesses?	❒ Yes	❒ No	Explain:
Currently under physician's care?	❒ Yes	❒ No	Reason:
Currently taking medication?	❒ Yes	❒ No	List:
Allergies?	❒ Yes	❒ No	List:
Drug sensitivity?	❒ Yes	❒ No	List:
Girls: Is she pregnant?	❒ Yes	❒ No	
Does the patient smoke?	❒ Yes	❒ No	

Please check if patient has or has had any of the following:

- ❒ Anemia
- ❒ Blood Disease
- ❒ Prolonged Bleeding
- ❒ Hepatitis
- ❒ AIDS antibody positive
- ❒ Jaundice
- ❒ Rheumatic Fever
- ❒ Heart Murmur
- ❒ Heart Disease
- ❒ Tuberculosis
- ❒ Diabetes
- ❒ Endocrine Problems
- ❒ Bone Disorders
- ❒ Epilepsy
- ❒ Herpes
- ❒ Frequent Colds or Flu
- ❒ Hearing Problems
- ❒ Tonsilitis/Adenitis
- ❒ Tonsils Removed: Age: _____
- ❒ Adenoids Removed: Age: _____
- ❒ Asthma
- ❒ Mouthbreathing
- ❒ Emotional Problems

Does the patient require pre-medication with antibiotics prior to dental treatment? ❒ Yes ❒ No If so, what? _____

Growth Information for Patients Under 16 Years of Age

Father's Height: _____ Mother's Height: _____ Is the child adopted? ❒ Yes ❒ No

Patient resembles: ❒ Mother ❒ Father ❒ Neither parent

Girls: Has she started menstruation: ❒ No ❒ Yes If so, When? _____

Boys: Has his voice changed: ❒ No ❒ Yes If so, When? _____

Names and ages of patient's brothers and sisters: _____

Have any family members had Orthodontic treatment? ❒ Yes ❒ No When? _____

DENTAL HISTORY

Name and address of patient's general dentist? _____

When did patient last see the dentist? _____ How often does the patient see the dentist? _____

Has the patient had any severe head or face injuries? ❒ Yes ❒ No Explain: _____

Has the patient had a history of thumb sucking or finger sucking? ❒ Yes ❒ No Stopped? ❒ Yes ❒ No

Does the patient play any musical (wind) instruments? ❒ Yes ❒ No Which: _____

Has the patient consulted an orthodontist previously? ❒ Yes ❒ No Explain: _____

Has the patient had any previous orthodontic treatment? ❒ Yes ❒ No Explain: _____

- ❒ Clenching Teeth
- ❒ Grinding Teeth
- ❒ Ringing in the Ears
- ❒ Jaw Joint Soreness
- ❒ Jaw Joint Clicking
- ❒ Jaw Joint Popping
- ❒ Headaches (more than normal)
- ❒ Muscular Soreness around Head and Neck

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

This office will accept the assignment of benefits from your insurance company. However, in the event of double or multiple coverage, we will accept the assignment from the primary carrier only. Services rendered are charged to the patient/parent, not the insurance company, and patients are expected to take care of their fees as services are rendered. In separation/divorce situations, the individual who initiates services with us is held responsible. **WE WILL NOT BILL ANOTHER PERSON OR AN ESTRANGED SPOUSE UNLESS THAT INDIVIDUAL INFORMS US IN WRITING OF HIS OR HER WILLINGNESS TO PAY FOR SERVICES.**

4/03 THANK YOU! Signed: _____ Date: _____