

ORTHODONTIC ACQUAINTANCE FORM

(Please Print)

Patient's Full Name _____ Date _____
Nickname (name called by) _____ O Male O Female
Patient's Age _____ Birthdate ____ - ____ - ____ School (if appl.) _____
Patient's Address _____
City _____ State _____ Zip _____ Home Phone # _____
Employed By _____ Work Phone # _____
Patient's Marital Status (if appl.) O Single O Married O Divorced O Other
Any Family or Friends that we have seen (give names)? _____
Referred by _____ Brother and/or Sisters and their Age _____
Patient's Physician _____ Patient's Dentist _____
Name of person responsible for account _____ Ss# _____
Address (if different from patient's) _____

For minors please complete the following:

Patient's Father's name _____ Home phone# _____
Employed by _____ SS# _____
Business Address _____ Bus. phone# _____
Patient's Mother's name _____ Home phone# _____
Employed by _____ SS# _____
Business Address _____ Bus. phone# _____
Parent's Marital Status O Single O Married O Divorced O Other
Name of insurance co.(If appl.) _____ Group # _____

MEDICAL HISTORY Circle yes or no the each question:

Please list any allergies to medications: _____
Is patient in good health? Yes No
Does patient have any history of major illness? Yes No
Is patient under care of physician? Yes No
If yes, for what? _____
Is pre-medication required for any dental procedures? Yes No

Indicate which of the following the patient has had, or has of present.

Diabetes	Yes	No	Fainting or Dizziness	Yes	No
Pneumonia	Yes	No	Psychiatric Care	Yes	No
Heart Trouble	Yes	No	Nervous Disorder	Yes	No
Rheumatic Fever	Yes	No	Liver Involvement	Yes	No
Mitral Valve Prolapse	Yes	No	Endocrine Problems	Yes	No
Heart Murmur	Yes	No	Hepatitis A (infectious)	Yes	No
Artificial Joint	Yes	No	Hepatitis B (Serum)	Yes	No
Bone Disorders	Yes	No	H.I.V, positive	Yes	No
Anemic	Yes	No	Allergies	Yes	No
Epilepsy	Yes	No	Hemophilia	Yes	No
Asthma	Yes	No	Blood Transfusions	Yes	No
Kidney Involvement	Yes	No	Latex Sensitivity	Yes	No

Do you have any disease or problem not listed above? _____

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth?.....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?.....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 and hobbies: _____

Reason for consultation: _____