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Orthodontic Acquaintance Form

Patient's Name _____ (First / Last) Sex: Male Female Date of Birth ___/___/___

Patient's Address _____ (City / State / Zip)

Email Address _____ Patient's Phone # (___) _____

Patient's Dentist _____ Physician _____ Referred by _____

Nearest relative to contact in case of an emergency: Name _____ Phone #(___) _____

FOR ADULT PATIENTS

Patient's Occupation _____ Employer _____ Business # _____ Cell # _____

Spouse's Name _____ Employer _____ Business # _____ Cell # _____

FOR DEPENDENT PATIENTS

School _____ Grade _____ Age _____

Mother's Name _____ (First / Last) Occupation _____ Date of Birth ___/___/___

Employed by _____ Business # _____ Cell # _____

Home Address & Phone # (if different) _____ (___) _____

Father's Name _____ (First / Last) Occupation _____ Date of Birth ___/___/___

Employed by _____ Business # _____ Cell # _____

Home Address & Phone # (if different) _____ (___) _____

MEDICAL HISTORY

Is patient in good health? Yes No
Is patient pregnant or think she might be? Yes No
Does patient have any history of major illness? Yes No
Has patient ever been under the care of a physician for illness? Yes No
If yes, why? _____

CHECK ANY OF THE FOLLOWING THAT APPLY:

☐ Heart Murmur	☐ Epilepsy	☐ Nervous Disorders
☐ Rheumatic Fever	☐ Diabetes	☐ Endocrine Problems
☐ Heart Trouble	☐ Hepatitis	☐ Prolonged Bleeding
☐ HIV Infection	☐ Tuberculosis	☐ Liver Involvement
☐ Jaundice	☐ Pneumonia	☐ Kidney Involvement
☐ Glaucoma	☐ Anemia	☐ Fainting or Dizziness
☐ Asthma	☐ Leukemia	☐ Arthritis / Bone Disease

Circle if the patient has tendency to: Colds Sore Throats Ear Infections
Have tonsils and adenoids been removed? At what age? _____
Does patient wear contact lenses? Yes No
Does patient gag easily? Yes No

DENTAL HISTORY

Have there been any injuries to the face, mouth, teeth or jaw? Yes No
Has patient ever sucked a thumb or fingers? Yes No
Does patient have any speech problems? Yes No
Is patient a mouth breather? While awake? Yes No
While asleep? Yes No
Does patient have missing or extra permanent teeth? Yes No
Has an orthodontist been consulted previously? Yes No
Has either parent had orthodontic treatment? Yes No
Does patient have clicking or popping when opening or closing jaw? Yes No
Has patient had any problems with wisdom teeth? Yes No
When did patient begin teething? (circle one) Early Average Late
In your own words, what is the problem? _____

Do you anticipate a transfer or move in the near future? Yes No
Do you have any special concerns about undergoing orthodontic treatment?

List any allergies or medications now being taken. (Give reasons)

FOR DEPENDENT PATIENTS

Females Has she started menstruation? Yes No
Height _____ Weight _____

Males Has his voice changed? Yes No
Height _____ Weight _____

I consent to have diagnostic radiographs taken on myself/my son/daughter/dependent during their initial exam.

To the best of my knowledge, all of the preceding answers are true and correct. If ever my health or medical history ever changes, I will inform the doctor at the next appointment without fail.

PARENT/PATIENT SIGNATURE _____ **DATE** ___/___/___