

ORTHODONTIC ACQUAINTANCE--PERSONAL INFORMATION DATE TODAY: _____

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

Home Address: _____ Date of birth: _____

Home Phone: _____ Name of Family Physician: _____

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

Information for Patients Who are MINORS:

School: _____ Grade: _____

Interests: _____

Childs attitude towards: Brushing _____ Dentistry: _____ Orthodontics: _____

FATHER

MOTHER

Name: _____

Address & Phone #: _____

Place of Business: _____

Business Phone #: _____

Occupation: _____

Parent's marital status: Married _____ Separated _____ Widowed _____ Divorced _____

(If divorced, who has custody of child? _____)

Please check length of time patient will be residing in Fayetteville:

___ Indefinitely ___ 1 year or less ___ 6 months or less /Explain: _____

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: _____

Allergics? ___yes ___no List: _____

Drug sensitivity? ___yes ___no List: _____

Currently taking medication? ___yes ___no List: _____

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

___yes ___no Anemia ___yes ___no Asthma ___yes ___no Tonsilitis/Adenitis

___yes ___no Blood Disease ___yes ___no Epilepsy ___yes ___no Tonsils removed: age _____

___yes ___no Tuberculosis ___yes ___no Rhucmatic fever ___yes ___no Adenoids removed: age _____

___yes ___no Prolonged bleeding ___yes ___no Emotional problems ___yes ___no Hepatitis

___yes ___no Diabetes ___yes ___no Heart Disease ___yes ___no Bone disorders

___yes ___no Endocrine problems ___yes ___no Frcquent colds or flu ___yes ___no Jaundice

___yes ___no Aids antibody positive ___yes ___no Hearing problems

___yes ___no Mouth breathing ___yes ___no Herpes

Growth information for patients under 16 years of age:

Father's height _____ Mother's height _____ Adopted? ___yes ___no

Patient resembles: ___neither parent ___Mother ___Father

Girls: Has she started menstruation? ___yes ___no When? _____

Boys: Has his voice changed? ___yes ___no When? _____

Names and ages of Patient's brothers & sisters? _____

Have any had Orthodontic Treatment? ___yes ___no When? _____

DENTAL HISTORY

Name of patient's General Dentist: _____

When did patient last see the dentist? _____

___yes ___no Has patient had any severe head or face injuries? Explain _____

___yes ___no Has patient had a history of thumb sucking or finger sucking? _____

___yes ___no Is habit stopped? _____

___yes ___no Does patient play any musical instruments? What? _____

___yes ___no Has patient consulted an orthodontist previously? If yes, explain: _____

___yes ___no Has patient had any previous orthodontic treatment? _____

Please check if you have a history of:

___Clinching teeth ___Headaches (more than usual) ___Grinding teeth ___Jaw Joint Soreness

___Muscular soreness around head and neck ___Jaw Joint Clicking ___Jaw Joint Popping ___Ringing in the Ears

Is there any other information that may be helpful? _____

Why are you seeking orthodontic evaluation? _____

Person responsible for payment of account? _____

This office will assist you in filing your insurance. Services rendered are charged to the patient, 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 financially responsible. We do not bill another person or an estranged spouse unless the individual informs us in writing of his or her willingness to pay for services.

Thank you!

Signed _____

Date _____