Orthodontic Acquaintance • PERSONAL INFORMATION Date Today: _____

Patient's Name: _____ Nickname: _____ 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: _____

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

	FATHER	**MOTHER**
Name:		
Address & Phone No. (If different from above):		
Place of Business:		
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: _____

Please check if Patient Has or Had Any of the Following:

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease	☐	☐	Frequent Colds or Flu
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Hearing Problems
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Tonsillitis/Adenitis
☐	☐	Hepatitis	☐	☐	Endocrine Problem	☐	☐	Tonsils Removed: Age: _____
☐	☐	AIDS antibody positive	☐	☐	Bone Disorders	☐	☐	Adenoids Remove: Age: _____
☐	☐	Jaundice	☐	☐	Epilepsy	☐	☐	Asthma
☐	☐	Rheumatic Fever	☐	☐	Herpes	☐	☐	Mouthbreathing _____
						☐	☐	Emotional Problems

Has anyone in your family been seen here before?

☐ Yes ☐ No If yes, state who: _____

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? ☐ No ☐ Yes When? _____

Boys: Has his voice changed? ☐ No ☐ Yes When? _____

Names and Ages of Patient's Brothers and Sisters? _____

Have any had Orthodontic Treatment? ☐ No ☐ Yes When? _____

DENTAL HISTORY

Name and address of patient's general dentist? _____

When did patient last see the dentist? _____

YES	NO	
☐	☐	Has the patient had any severe head or face injuries? Explain: _____
☐	☐	Has the patient had a history of thumb sucking or finger sucking? Stopped? _____
☐	☐	Does the patient play any musical (wind) instruments? What? _____
☐	☐	Has the patient consulted an orthodontist previously? _____
☐	☐	Has the patient had any previous orthodontic treatment? _____

PLEASE CHECK IF THERE IS A HISTORY OF:

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

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

Person responsible for payment of account? _____

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 that individual informs us in writing of his or her willingness to pay for services.

THANK YOU! **Signed:** _____ **Date:** _____