ORTHODONTIC PATIENT INFORMATION ACQUAINTANCE FORM

Welcome to our office.

The following information is requested to enable us to give you the best consideration for your orthodontic problem during your initial examination in our office. In oder for the doctor to throughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated. Thank you.

Patient's Last Name ____________________ First ____________ Nickname ______________

Home Phone No. ____________________

Birthdate ____________________ Age Yr ________ Mo. ________ Sex ________

School ____________________ Phone No. ____________ Grade ____________

Hobbies ____

Referred by ____________________ Address ____________________

Employer ____________________ Insurance ____________________

Group ____________________ Sub. ____________________

Ann. Date ____________________ Ortho Cov. ____________________ Max. __________

Father's/Husband's Name ____________________ Occupation ____________________

Address (if different) ____

Employed by ____________________ Bus. Telephone ____________________

Business Address ____

Mother's/Wife's Name ____________________ Occupation ____________________

Employed By ____________________ Bus. Telephone ____________________

Business Address ____

Names & Ages of Other Children in Family ____

Person Responsible For This Account ____

Credit References: Name ____________________ Address ____________________

Name ____________________ Address ____________________

Family Status: ____

Family Dentist: ____________ Phone No. __________ Family Physician ____________ Phone No. __________

Other Family Members With Similar Orthodontic Conditions?

Father Mother Brother Sister Other (specify) ____________________

Patient's Marital Status ____________________

Patient Living With

Father Mother Self Other (specify) ____________________

MEDICAL & DENTAL HISTORY

Present Health **Good** **Fair** **Poor** **Under treatment** ☐ Yes ☐ No

Specify ____________________

Present Drugs or Medication, or minerals or vitamins ☐ Yes ☐ No

Specify ____________________

Has patient been under care of Physician during the past two years other than for routine examination ☐ Yes ☐ No

Birth defects ☐ Yes ☐ No

Specify ____________________

Has patient reached puberty (menstruation, hair, voice change)? ☐ Yes ☐ No

Height ____________________ **Weight** ____________________

Has the patient ever had:

Asthma	☐ Yes	☐ No	**Diabetes**	☐ Yes	☐ No	**Liver Disorder**		
Anemia	☐ Yes	☐ No	**Epilepsy**	☐ Yes	☐ No	**(Hepatitis)**	☐ Yes	☐ No
Blood disease			**Endocrine problems**	☐ Yes	☐ No	**Heart Disease**	☐ Yes	☐ No
(Prolonged bleeding)	☐ Yes	☐ No	**Emotional Problems**	☐ Yes	☐ No	**Head of Face Injury**	☐ Yes	☐ No
Bone disorders	☐ Yes	☐ No	**Hearing Disorder**	☐ Yes	☐ No	**Rheumatic Fever**	☐ Yes	☐ No
Fainting or dizzy	☐ Yes	☐ No				**Kidney Involvement**	☐ Yes	☐ No

Comments ____________________

____

____

Does the patient:

1. Have allergies to:

Seasonal Grass __________ **Food** __________ **Drugs** __________ **Other** __________

2. Snore when sleeping? ☐ Yes ☐ No

3. Breath through mouth? ☐ Yes ☐ No

4. Have frequent colds ☐ Yes ☐ No

5. Have frequent sore throat or tonsillitis? ☐ Yes ☐ No

6. Have chewing or swallowing difficulty? ☐ Yes ☐ No

Has the patient received medical treatment from allergist or ear, nose and throat specialist? ☐ Yes ☐ No

If yes: **When:** ____________________

Tonsils removed: ____________________

Use of Nasal Spray: ____________________

Does the patient have pain or clicking in jaw joint? ☐ Yes ☐ No

Have any teeth been injured due to accidents or blows to the mouth? ☐ Yes ☐ No

Has the patient received or been requested to receive speech correction? ☐ Yes ☐ No

The following habits are of interest to the doctor. List information as it pertains to this patient

Thumb sucking until age ______ Grinding of teeth ☐ Yes ☐ No

Finger sucking until age ______ Tongue thrusting ☐ Yes ☐ No

Other habits ______ Lip biting or sucking ☐ Yes ☐ No

Has the patient had any unusual dental experiences? ☐ Yes ☐ No

Specify: ______

Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No

Date: ______ Doctor: ______

Are there any other medical, dental or surgical problems not covered above? ☐ Yes ☐ No

Specify: ______

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT

Dental checkups: Twice a year Once a Year Only if Urgent Never

Date of last dental checkup ______ Were the patient's teeth cleaned? ☐ Yes ☐ No

Is the patient aware of any orthodontic problem? ☐ Yes ☐ No

Patient'sinterest in orthodontic treatment Patient wants treatment Treatment if necessary Unwilling but Agrees Uncooperative

Patient's consultation prompted by: Patient Dentist Mother Father Spouse Sibling Physican Friend

Other (specify) ______

Why did the patient seek this consultation? ______

What is the primary problem? ______

______

What is expected from orthodontic treatment? ______

Additional comments you wish to make: ______

______

______

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM ______

Relationship to Patient: ______ Date: ______

GENERAL RELEASE

I the undersigned, certify that I have provided an accurate and complete personal and medical history and have not knowingly omitted any information. I have had the opportunity to ask and receive answers to questions regarding my medical-dental history. I realise that the dentist is a general practitioner who offers orthodontic treatment to patients. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as maybe required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary, and I consent to the responsibility for payment of the dental services for myself and my dependants is mine solely, and I assume responsibility for fees associated with these services. Our office requires three working days notification, should you be unable to keep the scheduled appointment time. There is a minimum charge for missed appointments.

X ______ ______

(signature) Parent / Guardian (print name)

Reviewed by Treating dentist: ______ Date: ______