ORTHODONTIC AQUAINTANCE FORM

PRACTICE LIMITED TO ORTHODONTICS

DATE_____

NAME_____NICKNAME_____

AGE_____BIRTHDATE_____SEX_____SOCIAL SECURITY#_____

HOME ADDRESS_____

EMAIL_____HOME PHONE_____

SCHOOL_____GRADE_____HOBBIES/SPORTS_____

DOES YOUR CHILD PLAY A MUSICAL INSTRUMENT?___IF YES, WHAT KIND_____

FATHER'S NAME_____CELLULAR PHONE_____

HOME ADDRESS_____HOME PHONE_____

MOTHER'S NAME_____CELLULAR PHONE_____

HOME ADDRESS_____HOME PHONE_____

PLEASE LIST SIBLINGS AND DATE OF BIRTH_____

PERSON RESPONSIBLE FOR PAYMENT_____RELATIONSHIP_____

DO YOU HAVE ORTHODONTIC INSURANCE?_____IF YES, NAME OF CARRIER_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

CHILD'S DENTIST_____PHONE_____DATE OF LAST VISIT_____

HOW WOULD YOU DESCRIBE YOUR CHILD'S ORAL HYGIENE?_____

HAS YOUR CHILD HAD A PREVIOUS ORTHODONTIC CONSULTATION?_____

HAS ANY RELATIVE HAD ORTHODONTIC TREATMENT?____IF YES, RELATIONSHIP_____

HAS YOUR CHILD HAD ANY INJURY TO THE TEETH OR HEAD?____IF YES, EXPLAIN_____

_____

HAS YOUR CHILD UNDERGONE SPEECH OR MYOFUNCTIONAL THERAPY?_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? PLEASE CHECK ANY THAT APPLY

FINGER SUCKING_____NAIL BITING_____LIP BITING_____PENCIL/OBJECTS BITING_____

MOUTH BREATHING____GRINGING OF TEETH____OTHER_____

DESCRIBE WHAT YOU WOULD LIKE US TO ACCOMPLISH FOR YOUR CHILD_____

_____

MEDICAL HISTORY

CHILD'S PHYSICIAN_____ _____ADDRESS_____ _____ _____

IS YOUR CHILD PRESENTLY IN GOOD HEALTH?_____HAS YOUR CHILD BEEN UNDER A

PHYSICIAN'S CARE IN THE LAST 5 YEARS?_____IF YEA, PLEASE EXPLAIN_____

_____

IS YOUR CHILD TAKING ANY MEDICATION AT THE PRESENT TIME?_____IF YES PLEASE LIST

MEDICATION AND REASON:_____

IS YOUR CHILD ALLERGICE TO LATEX?_____IS YOUR CHILD ALLERGICE TO ANY DRUGS_____

PENICILLIN?_____OTHERS?_____

DOES YOUR CHILD HAVE A HISTORY OF HEART DISEASE_____FREQUENT EAR ACHES_____

ASTHMA_____BLEEDING TENDENCIES_____CONVULSIONS_____EPILEPSY_____

ENDOCRINE (GLAND) DISORDER_____RHEUMATIC FEVER_____SCARLET FEVER_____

PLEASE NOTE ANY OTHER MEDICAL CONDITIONS_____

_____

_____

GROWTH INFORMATION

DOES YOUR CHILD RESEMBLE THE FATHER OR MOTHER?_____

FATHER'S HEIGHT_____MOTHER'S HEIGHT_____

FEMALE PATIENTS: HAS PATIENT STARTED MENSTRUATION?_____DATE_____

AT WHAT AGE DID HER SISTERS START?_____

MALE PATIENTS: HAS PATIENT'S VOICE CHANGED?_____

HAS PATIENT STARTED SHAVING?_____DOES PATIENT HAVE ACNE?_____

HOW WOULD YOU DESCRIBE YOUR CHILD'S PERSONALITY? SHY_____SENSITIVE_____

OUTGOING_____OTHER_____

OTHER RELEVANT INFORMATION_____

_____

_____

SIGNATURE OF PARENT/GUARDIAN DATE