ID # _____

ORTHODONTIC ACQUAINTANCE CARD

DATE OF EXAM _____

NICKNAME _____ DATE OF BIRTH _____

PATIENT'S NAME _____ FIRST _____ INITIAL _____ AGE _____ SEX _____

RESIDENCE ADDRESS _____ CITY _____ ZIP _____ RESIDENCE PHONE _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

PERSON RESPONSIBLE FOR ACCOUNT _____

LIST NAME OF INSURANCE PLAN COVERING ORTHODONTIC TREATMENT (IF ANY) _____

PATIENT'S OCCUPATION _____ EMPLOYED BY _____ BUS. PHONE _____

IF PATIENT MARRIED: SPOUSE NAME _____ EMPLOYED BY _____ BUS. PHONE _____

PATIENT'S FATHER'S NAME _____ EMPLOYED BY _____ BUS. PHONE _____

BUSINESS ADDRESS _____ OCCUPATION _____

PATIENT'S MOTHER'S NAME _____ EMPLOYED BY _____ BUS. PHONE _____

BUSINESS ADDRESS _____ OCCUPATION _____

PARENTS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____

MEDICAL HISTORY

Height _____ Weight _____ Is patient in good health? _____ ☐ Yes ☐ No

Does patient have any history of major illness? _____ ☐ Yes ☐ No

Any birth defects? Please list: _____ ☐ Yes ☐ No

Check any of the following for which the patient has been treated:

DIABETES . . . . . ☐	TUBERCULOSIS . . . . . ☐	ENDOCRINE PROBLEMS . . . ☐	ALLERGIES . . . . . ☐
PNEUMONIA . . . . . ☐	ANEMIA. . . . . ☐	PROLONGED BLEEDING . . . . ☐	CONVULSIONS . . . . . ☐
HEART TROUBLE . . . . . ☐	EPILEPSY. . . . . ☐	FAINTING OR DIZZINESS . . . ☐	ULCERS . . . . . ☐
RHEUMATIC FEVER . . . . . ☐	ASTHMA . . . . . ☐	NERVOUS DISORDERS . . . . . ☐	MENINGITIS . . . . . ☐
BONE DISORDERS . . . . . ☐	KIDNEY INVOLVEMENT . . . . . ☐	LIVER INVOLVEMENT . . . . . ☐	ARTHRITIS . . . . . ☐

Infectious Diseases i.e. Hepatitis, HIV/AIDS? _____ ☐ Yes ☐ No

Familial Diseases i.e. Diabetes, Cancer? _____ ☐ Yes ☐ No

Is patient pregnant? _____ ☐ Yes ☐ No

Has the patient ever been under the care of a physician for illness? _____ ☐ Yes ☐ No

Does patient have tendency to: ☐ colds ☐ sore throats ☐ ear infections _____ ☐ Yes ☐ No

Have tonsils and adenoids been removed? What age? _____ ☐ Yes ☐ No

Other operations? _____ ☐ Yes ☐ No

Any broken bones? Please list: Did they heal satisfactorily? _____ ☐ Yes ☐ No

List any drug allergies or sensitivity: _____

Presently taking medications? Please list: _____ ☐ Yes ☐ No

Any psychological counseling? _____ ☐ Yes ☐ No

Does patient require premedication for dental procedures? _____ ☐ Yes ☐ No

Does patient have a heart murmur? _____ ☐ Yes ☐ No

Has the patient reached puberty? Boys - Has his voice changed? Girls - Has she started menstruation? _____ ☐ Yes ☐ No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? Date: _____ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? Until what age? _____ ☐ Yes ☐ No

Any lip or nail biting? _____ Other Habits _____ ☐ Yes ☐ No

Does the patient have any speech problems? _____ ☐ Yes ☐ No

Is the patient a mouth breather? _____ ☐ While awake ☐ While asleep _____ ☐ Yes ☐ No

Are lips apart often? _____ ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Has either parent or other children had orthodontic treatment? _____ ☐ Yes ☐ No

Any pain in or near the ears: ☐ Right ☐ Left _____ ☐ Yes ☐ No

Any clicking or discomfort of the jaw joint near ears? ☐ Right ☐ Left _____ ☐ Yes ☐ No

Any apprehension or unfavorable experience in a dental office? _____ ☐ Yes ☐ No

Last visit to a dentist: _____ Date of last dental X-rays: _____

List sports and hobbies _____

Does the patient complete work assigned to do? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

Most important: Does patient want orthodontic treatment? _____ ☐ Yes ☐ No

What would you wish to gain by orthodontic treatment? _____

Date: _____ _____

Signature of Patient, Parent or Guardian

Consent for Orthodontic Exam and Treatment