ORTHODONTIC ACQUAINTANCE CARD

ID # _____

DATE OF EXAM _____

NICKNAME _____ DATE OF BIRTH _____

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

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'S 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: ☐ DIVORCED ☐ SEPARATED ☐ MARRIED

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, AIDS, HIV ? _____ ☐ 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 medication? Please list: _____ ☐ Yes ☐ No

Any psychological counseling? _____ ☐ Yes ☐ No

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

Other: _____

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 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

Does patient vomit, gag or faint easily? _____ ☐ Yes ☐ No

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

List sports, hobbies and musical instruments _____

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 & Treatment