

ORTHODONTIC ACQUAINTANCE INFORMATION

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Who may we thank for referring you to our office? _____

PATIENT INFORMATION

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

PREFERRED NAME: _____ **AGE:** _____ **SEX:** _____

PRESENT ADDRESS: _____ **PHONE:** _____

E-MAIL ADDRESS: _____ **PLACE OF EMPLOYMENT** _____

RESPONSIBLE PARTY INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT: _____ **SS#:** _____

PRESENT ADDRESS: _____ **WORK PHONE:** _____

MEDICAL AND DENTAL HISTORY

PRIMARY ORTHODONTIC CONCERN: _____ **PATIENT'S DENTIST** _____

NAMES OF OTHER FAMILY MEMBERS WHO WILL NEED ORTHODONTIC TREATMENT _____

PHYSICIAN: _____ **ADDRESS:** _____

Is the patient in good health?.....() Yes () No Does the patient have a history of major illness?.....() Yes () No

Does the patient have a history of any of the following?.....

Diabetes () Tuberculosis () Endocrine Problems () Pneumonia () Prolonged Bleeding () Anemia () Heart Trouble () Seizures ()

Asthma () Rheumatic Fever () Nervous Disorders () Bone Disorders () Kidney Problems () Hepatitis () Liver Problems () AIDS/HIV ()

LIST OF MEDICATIONS PRESENTLY TAKEN AND REASON: _____

LIST ANY ALLERGIES OR DRUG SENSITIVITIES: _____

Does the patient have routine dental checkups? _____ Has the patient had a recent dental checkup? _____

Does the patient have any speech problems? _____ Have you been informed of any missing or extra teeth? _____

Has an orthodontist been consulted previously? _____ Does the patient have any oral habits? (Ex. Thumb sucking) _____

Does the patient grind or clench teeth? _____ Is there pain or noise in either jaw? _____

If female, is there any possibility you are pregnant? _____ Trimester? ____ Has there been any injury to the face, jaw, or mouth? _____

I understand that, where appropriate, credit bureau reports may be obtained.

Patient's/ Parent's Signature

Date