ORTHODONTIC ACQUAINTANCE CHART

Nick Name_____ Date _____ Sex: Male / Female

Patient's Name _____ Birth Date _____ Age_____ yrs. mos.

Home Address _____ Phone ( )_____
street city zip

No. of Children in Family_____ Patient's Physician_____ Dentist_____

School_____ Grade_____ Who referred you to our office? _____

Father's Name _____ Occupation _____ Employed by _____

Business Address_____ Phone _____
street city zip

Mother's Name _____ Occupation _____ Employed by_____

Business Address_____ Phone_____
street city zip

Person financially responsible?_____

Are parents divorced? _____ Separated? _____ Widowed?_____

Dental Insurance? Yes / No Plan Name _____

Email Address _____

MEDICAL HISTORY (circle yes or no and fill in blanks where required)

1. Is the patient in good health? ..... No Yes
2. Have tonsils and/or adenoids been removed? At what age?_____ ..... No Yes
3. Has patient reached puberty? ..... No Yes
4. Are height and weight normal for age? ..... No Yes
5. Frequent colds, sore throat, or ear infections? ..... No Yes
6. Any history of immune deficiency disease? _____ No Yes
7. Any history of major illness? If yes, list_____ No Yes
8. Any allergies or drug sensitivity? If yes, list _____ No Yes
9. Taking medications now? If yes, list _____ No Yes
10. Under medical care now? Reason _____ No Yes
11. Does patient require antibiotics before dental appointments? ..... No Yes
12. Please circle any of the following for which the patient has been treated:

Diabetes	Asthma	Infectious Hepatitis	Tonsillitis
Arthritis	Epilepsy	Nervous Disorders	Brian Injury
Heart Trouble	Rheumatic fever	Endocrine Problems	Tuberculosis

DENTAL HISTORY

12. Date of last dental exam _____ Is work completed? ..... No Yes
13. Have full mouth x-rays ever been taken? If yes, give date_____ ..... No Yes
14. Have there been any injuries to the face, mouth, or teeth? ..... No Yes
15. Has patient ever sucked thumb or fingers? Until what age?_____ ..... No Yes
16. Has patient ever had oral habits, such as lip biting or tongue thrusting? ..... No Yes
17. Any finger nail biting? ..... No Yes
18. Does patient have any speech problems? ..... No Yes
19. Has patient ever had any speech therapy? ..... No Yes
20. Is the patient a mouth breather while asleep or awake? ..... No Yes
21. Are you aware of any missing or extra permanent teeth? ..... No Yes
22. Has an orthodontist been consulted previously? ..... No Yes
23. Have either parent or other children had orthodontic treatment? ..... No Yes

    If so, where? _____
24. Would you consider the patient's diet high in sweets? ..... No Yes
25. List any musical instruments played _____ How long? _____
26. What are you most concerned about? _____

_____

27. What is your dentist most concerned about? _____
28. Person filling out this form _____ Relationship _____