ORTHODONTIC ACQUAINTANCE CARD

DATE _____ 20___ PATIENT NAME _____ DATE OF BIRTH _____ SEX _____
LAST FIRST INITIAL

REASON FOR CONSULTATION _____ AGE: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ HOME TELEPHONE _____

E-MAIL ADDRESS _____ SCHOOL _____ GRADE _____

PATIENT DENTIST _____ PHYSICIAN _____ ORAL SURGEON _____

FATHER'S NAME _____ S.S. #_____ DATE OF BIRTH _____

EMPLOYED BY _____ WORK PHONE _____ OCCUPATION _____

HOME ADDRESS _____ CELL PHONE _____ CARRIER _____

MOTHER'S NAME _____ S.S. # _____ DATE OF BIRTH _____

EMPLOYED BY _____ WORK PHONE _____ OCCUPATION _____

HOME ADDRESS _____ CELL PHONE _____CARRIER _____ PARENTS MARRIED / DIVORCED

NAMES AND AGES OF OTHER CHILDREN IN FAMILY _____ IF DIVORCED, WHO IS CUSTODIAL PARENT? MOTHER / FATHER

NAMES OF FAMILY MEMBERS TREATED IN OUR OFFICE _____

PERSON RESPONSIBLE FOR ACCOUNT _____ AS A **CREDIT GRANTOR, CREDIT CHECKS ARE NECESSARY FOR CONTRACT ARRANGEMENTS**

PHONE _____ S.S.# _____ RELATIONSHIP TO PATIENT _____

INSURANCE YES/NO IF MULTIPLE INSURANCE, PLEASE LIST PRIMARY FIRST _____ INSURANCE CO. _____
INSURED

IS PATIENT IN GOOD HEALTH YES ☐ NO ☐ IF NO, PLEASE EXPLAIN _____

LIST ANY MAJOR ILLNESS _____ DOES PATIENT HAVE ANY MENTAL OR PHYSICAL HANDICAP OR LEARNING DISABILITY WHICH MIGHT LIMIT ABILITY TO FOLLOW INSTRUCTIONS
YES ☐ NO ☐ EXPLAIN _____

CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED:

DIABETES	☐	TUBERCULOSIS	☐	ENDOCRINE PROBLEMS	☐	TENDENCY TO: COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐
PNEUMONIA	☐	ANEMIA	☐	PROLONGED BLEEDING	☐	HAVE TONSILS & ADENOIDS BEEN REMOVED? YES ☐ NO ☐
HEART TROUBLE	☐	EPILEPSY	☐	FAINTING OR DIZZINESS	☐	WHAT AGE _____
RHEUMATIC FEVER	☐	ASTHMA	☐	NERVOUS DISORDER	☐	
BONE DISORDER	☐	KIDNEY INVOLVEMENT	☐	LIVER INVOLVEMENT	☐	LATEX ALLERGY YES☐ NO☐
HEPATITIS	☐	OTHER	☐			

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN _____ **REASON** _____ **DRUG ALLERGY** _____
_____ **REASON** _____
_____ **REASON** _____

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURY TO MOUTH OR TEETH _____ YES ☐ NO ☐
HAS THIS PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES ☐ NO ☐
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES ☐ NO ☐
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?_____ YES ☐ NO ☐

DOES THIS PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES ☐ NO ☐
IS THIS PATIENT A MOUTH BREATHER? WHILE ASLEEP _____ YES ☐ NO ☐
WHILE AWAKE _____ YES ☐ NO ☐
LIST ANY MUSICAL INSTRUMENTS PLAYED _____ YES ☐ NO ☐
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT _____ YES ☐ NO ☐

WHO SHALL WE THANK FOR REFERRING PATIENT TO US _____

_____
PARENT / GUARDIAN SIGNATURE