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Specialist in Orthodontics—Adults and Children

Child Acquaintance Sheet

Date: _____
Name: _____Nickname: _____
Sex: _____ Date of Birth:_____ Age: Years _____ Months_____
Address:_____
City: _____State:_____ Zip: _____
Telephone:_____
Primary Household E-mail Address: _____
Dentist: _____ Telephone: _____
Address:_____
Physician: _____ Telephone: _____
Address _____
Reason you are seeking orthodontic treatment: _____
_____

Family History

Parents (please check one):
☐ Living together ☐ Divorced ☐ Father Deceased ☐ Mother Deceased
☐ Separated ☐ Child Lives With ..... ☐ Mother ☐ Father
Father's Name: _____Soc. Sec. #: _____
Address:_____
City: _____ State: _____Zip: _____
Occupation: _____ Bus. Telephone: _____
Employer's Name and Address: _____
_____
Dental Insurance Name: _____

Mother's Name:_____ Soc. Sec. #: _____
Address:_____
City: _____ State: _____Zip: _____
Occupation: _____ Bus. Telephone: _____
Employer's Name and Address: _____
_____
Dental Insurance Name: _____
Names and ages of brothers and sisters: _____

Dental History

Date of last dental check-up: _____
Injury or Trauma to face or teeth: _____
Thumb sucking: ☐ Yes ☐ No Discontinued at what age: _____
Habits (e.g.: lip biting, nail biting, etc.): _____
Thumb sucking: ☐ Yes ☐ No Discontinued at what age:_____
Breathing: ☐ Nose ☐ Mouth Difficulty at night (yes or no): _____
Bruxism (grinding teeth): ☐ Yes ☐ No ☐ At night ☐ Daytime
Jaw joint problems (TMJ):
☐ Noise ☐ Pain ☐ Soreness & Stiffness ☐ Earaches/Ringing
Patient interest in treatment: ☐ Patient wants treatment
☐ Unwilling but agrees if treatment is necessary ☐ Uncooperative
Have you had any experience with or seen another orthodontist?
☐ Yes ☐ No If yes, Name? _____

Maturation

Have you grown very much in the past year? ☐ Yes ☐ No
Female patients: Monthly periods? ☐ Yes ☐ No Started age: _____
Is there any chance that you are pregnant? ☐ Yes ☐ No
Male Patients: Voice change ☐ Yes ☐ No Facial hair? ☐ Yes ☐ No

Medical History

General health: ☐ excellent ☐ fair ☐ poor
Presently under care for: _____
Birth Defects: _____
Drugs & Medications being taken now (drug and dose):
Allergic to what medications: _____
_____

Please circle any of the following which you have had or may have at the present time

Adenoids Removed
Allergies
AIDS (HIV Positive)
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disorder
Blood Transfusion
Bone Disorder
Breathing Difficulties
Cold Sores
Congenital Heart Disease
Convulsions
Damaged Heart Valve
Diabetes
Dizzines
Drug Addiction
Endocrine Disorder
Epilepsy
Epistaxis (nosebleeds)
Fainting Spells
Genital Herpes
Glaucoma
Hay Fever
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hepatitis
High Blood Pressure
Hospitalized
Hyperactivity
Injuries
Jaundice
Kidney Disorder
Liver Disorder
Lung Disorder
Mitral Valve Prolapse
Neurosis
Pain in Jaw Joint
Psychiatric Treatment
Rheumatic Fever
Rheumatism
Scoliosis
Seizures
Sinus Trouble
Tonsils Removed
Tuberculosis (TB)
Thyroid Disease
Venereal Disease
X-Ray treatmento (not diagnostic)
None of the Above

Do you have any medical conditions not listed above that you feel we should know about (Explain)? _____
_____
Please give greater details where necessary: _____
_____
_____
_____

Questionnaire completed by _____ Relation to patient _____
Whom may we thank for referring you to our office for orthodontics? _____
_____
Any additional comments? _____
_____
_____
_____