CONFIDENTIAL CHILD ORTHODONTIC ACQUAINTANCE CARD Date_____.

PATIENTS NAME (L.)_____(F)_____ (M.I.)___ DOB____/____/_____.

ADDRESS _____CITY_____ZIP_____.

HOME PHONE(____) _____E-Mail: _____FINANCIAL RESPONSIBILITY: F M S O

EMERGENCY CONTACT_____PHONE(___)_____.

HOBBIES _____SCHOOL_____GRADE _____.

INSURANCE COMPANY?:PRIMARY_____SECONDARY:_____.

PHYSICIAN_____DENTIST_____ REF_____☐.

FATHER'S NAME (L) _____(F)_____DOB:_____S.S.____ -____-____.

ADDRESS_____CITY_____ZIP_____

EMPLOYER_____Home Phone: (___)_____Cell Phone: (___)_____

MOTHER'S NAME (L) _____ (F) _____DOB:_____S.S.____- ____-____.

ADDRESS_____CITY_____ZIP_____ _____

EMPLOYER_____Home Phone: (___)_____Cell Phone: (___)_____.

NAMES AND BIRTHDATES OF ADDITIONAL CHILDREN (UNDER 18)_____.

DENTAL HISTORY

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?_____YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE?_____ YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS?_____.

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE?_____YES ☐ NO ☐ WHILE ASLEEP?_____YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING PERMANENT TEETH? _____ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?_____YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?_____YES ☐ NO ☐

IS PATIENT BEING TREATED FOR PERIODONTAL DISEASE, T.M.J, DENTAL ISSUES?_____ YES ☐ NO ☐

REASON FOR CONSULTATION:_____.

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? YES ☐ NO ☐ HEIGHT_____ WEIGHT_____.

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____YES ☐ NO ☐

HAS PATIENT EVER BEEN UNDER THE CARE OF PHYSICIAN FOR ILLNESS? _____YES ☐ NO ☐

PLEASE LIST:_____.

FILL OUT ANY OF THE FOLLOWING THAT APPLY FOR WHICH THE PATIENT HAS BEEN TREATED:

EYE/EAR/NOSE	☐ Y ☐ N	PNEUMONIA/RESPIRATORY	☐ Y ☐ N	RECENT LOSS OF WEIGHT	☐ Y ☐ N
ASTHMA	☐ Y ☐ N	PROLONG BLEEDING	☐ Y ☐ N	CANCER TREATMENT	☐ Y ☐ N
DIABETES	☐ Y ☐ N	SEIZURES/NEUROLOGICAL	☐ Y ☐ N	JOINT PROSTHETICS	☐ Y ☐ N
TUBERCULOSIS	☐ Y ☐ N	BIRTH DEFECTS/ HEREDITARY PROBLEMS	☐ Y ☐ N	KIDNEY PROBLEMS	☐ Y ☐ N
SKIN DISORDERS	☐ Y ☐ N	MENTAL/ANXIETY HEALTH DISORDERS	☐ Y ☐ N	RHEUMATIC FEVER	☐ Y ☐ N
SENSE OR SPEECH	☐ Y ☐ N	BONE FRACTURES/MAJOR ACCIDENTS	☐ Y ☐ N	AUTOIMMUNE DISORDER	☐ Y ☐ N
HYPERTENSION/HEART	☐ Y ☐ N	HEADACHES/ COLDS/ SORE THROAT	☐ Y ☐ N	FAINTING OR DIZZINESS	☐ Y ☐ N
HEPATITIS/LIVER	☐ Y ☐ N	CHEST PAIN/SHORTNESS OF BREATH	☐ Y ☐ N	EATING DISORDERS	☐ Y ☐ N
CARDIOVASCULAR	☐ Y ☐ N	ENDOCRINE/THYROID PROBLEMS	☐ Y ☐ N	TONSILS REMOVED	☐ Y ☐ N

TAKING ANY MEDICATION, SUPPLEMENTS, HERBAL MEDICATIONS OR NON-PRESCRIPTION MEDICATIONS? ☐ Y ☐ N

PLEASE LIST:_____

DRUG ALLERGIES AND SENSITIVITIES:

LOCAL ANESTHETICS	☐ Y ☐ N	ASPIRIN/IBUPROFEN	☐ Y ☐ N	PENICILLIN	☐ Y ☐ N
SULFA DRUGS	☐ Y ☐ N	CODEINE/NARCOTICS	☐ Y ☐ N	METALS(JEWELRY ETC)	☐ Y ☐ N
LATEX(GLOVES)	☐ Y ☐ N	VINYL	☐ Y ☐ N	ACRYLIC	☐ Y ☐ N

FOODS(SPECIFY)_____ OTHER SUBSTANCES_____

HAS THE PATIENT REACHED PUBERTY? BOY: YES ☐ NO ☐ GIRL: STARTED MENSTRATION? YES ☐ NO ☐ PREGNANT: YES ☐ NO ☐

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____ _____ _____ _____

(Patient/Parent/Guardian) Signature Date (Patient/Parent/Guardian) Signature Date

_____ _____ _____ _____

(Patient/Parent/Guardian) Signature Date (Patient/Parent/Guardian) Signature Date