ORTHODONTIC ACQUAINTANCE CARD

DATE OF EXAM _____
DATE OF BIRTH _____

PATIENT'S NAME: _____ AGE: _____ SEX: _____
LAST FIRST M.I.

ADDRESS: _____ CITY: _____ ZIP: _____ PHONE: _____

E-MAIL ADDRESS: _____ CELL PHONE: _____

SCHOOL: _____ GRADE: _____ REFERRED BY: _____

PATIENT'S DENTIST: _____ PHYSICIAN: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ RELATIONSHIP: _____

LIST NAME OF INSURANCE PLAN COVERING ORTHODONTIC TREATMENT (IF ANY): _____

PATIENT'S OCCUPATION: _____ EMPLOYED BY: _____ BUS. PHONE: _____

IF PATIENT MARRIED, SPOUSE'S NAME: _____ EMPLOYED BY: _____ BUS. PHONE: _____

PATIENT'S FATHER'S NAME: _____ EMPLOYED BY: _____ BUS. PHONE: _____

BUSINESS ADDRESS: _____ OCCUPATION: _____

PATIENT'S MOTHER'S NAME: _____ EMPLOYED BY: _____ BUS. PHONE:

BUSINESS ADDRESS: _____ OCCUPATION: _____

PARENTS: ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ OTHER

NAMES AND AGES OF OTHER CHILDREN IN FAMILY: _____

PATIENT'S SLEEPING POSTURE: ☐ ON BACK ☐ ON FACE ☐ ON LEFT SIDE ☐ ON RIGHT SIDE ☐ RESTLESS SLEEPER

ANY BIRTH DEFECTS? _____ PLEASE LIST: _____

MEDICAL HISTORY

Height: _____ Weight: _____ Is patient in good health? _____ ☐ Yes ☐ No

Does patient have any history of major illness? _____ ☐ Yes ☐ No

Check any of the following for which the patient has been treated:

DIABETES ..... [ ]	TUBERCULOSIS ..... [ ]	ENCOCRINE PROBLEMS..... [ ]
PNEUMONIA..... [ ]	ANEMIA ..... [ ]	PROLONGED BLEEDING..... [ ]
HEART TROUBLE ..... [ ]	EPILEPSY..... [ ]	FAINTING OR DIZZINESS..... [ ]
RHEUMATIC FEVER.... [ ]	ASTHMA..... [ ]	NERVOUS DISORDERS..... [ ]
BONE DISORDER..... [ ]	KIDNEY INVOLVEMENT..... [ ]	LIVER INVOLVEMENT ..... [ ]

Has the patient ever been under the care of a physician for illness? _____ ☐ Yes ☐ No

Does the patient have a tendency for: ☐ colds ☐ sore throats ☐ ear infections _____ ☐ Yes ☐ No

Have tonsils and adenoids been removed? What Age? _____ ☐ Yes ☐ No

Any broken bones? Please list: Did they heal satisfactorily? _____ ☐ Yes ☐ No

List any drug allergies or sensitivity: _____

Does patient bleed easily? _____ ☐ Yes ☐ No Have high fever with childhood diseases? _____ ☐ Yes ☐ No

Any psychological counseling? _____ ☐ Yes ☐ No

Other: _____

Has the patient reached puberty? Girls - Has she started menstruation? _____ ☐ Yes ☐ No

Boys - Has his voice changed? _____ ☐ Yes ☐ No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? Date: _____ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? Until what age? _____ ☐ Yes ☐ No

Any lip or nail biting? _____ Other _____ ☐ Yes ☐ No

Does the patient have any speech problems? _____ ☐ Yes ☐ No

Is the patient a mouth breather? ☐ While awake ☐ While asleep _____ ☐ Yes ☐ No

Are lips apart often? _____ ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? _____ ☐ Yes ☐ No

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Has either parent or other children had orthodontic treatment? _____ ☐ Yes ☐ No

List any musical instruments played with mouth or lips: _____

List sports and hobbies: _____

Does the patient vomit, gag or faint easily? _____ ☐ Yes ☐ No

Any pain in or near the ears? ☐ Right ☐ Left _____ ☐ Yes ☐ No

Any clicking or discomfort of the jaw joint near the ears? ☐ Right ☐ Left _____ ☐ Yes ☐ No

Any apprehension or unfavorable experience in a dental office? _____ ☐ Yes ☐ No

Has the patient ever been placed on an oral hygiene program by a general dentist? _____ ☐ Yes ☐ No

Last visit to a dentist: _____ Date of last dental X-rays: _____

Does the patient complete work assigned to do? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Rarely ☐ Never

Most important: Does the patient want orthodontic treatment? _____ ☐ Yes ☐ No

What would you wish to gain by orthodontic treatment? _____