ORTHODONTIC ACQUAINTANCE FORM

Name:____ Name patient prefers to be called:_________________________ Age: __________

Date of birth:_______________________________________ Sex: ☐ Male ☐ Female Home phone: ____

Mailing street or box #: ____ City/St./Zip: ____

Email ____ Text reminder: ☐ Yes ☐ No Carrier: _________________________________

Name of person responsible for account: ____ Cell phone: _________________________________

Billing street or box #: ____ City/St./Zip: ____

Do you have orthodontic coverage on your dental insurance: ☐ Yes ☐ No In whose name is the coverage: ____

If so, Name of company:____ Policy #: ____________________________ Group #: ___________________

Patient's dentist:____ Last visit to dentist: __________________ Physician: _______________________

Name and ages of children in the family: ____

Which friend may we thank for referring you?____________________________ Relationship: ☐ Former patient ☐ Family ☐ Friend ☐ Dentist ☐ Yellow Pages ☐ Radio ☐ TV ☐ Newspaper

COMPLETE ONLY IF ABOVE IS A MINOR

Father's Name:____

SS#: ___________________________ Bus. Phone: ___________________

DOB:___________________________ Driver's Lic. #: _________________

Employed By: ____

Occupation: ____

Employer's Address: ____

Mother's Name: ____

SS#: ___________________________ Bus Phone: ___________________

DOB:___________________________ Driver's Lic. #: _________________

Employed By: ____

Occupation: ____

Employer's Address: ____

Are Parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

School: _______________________________________ Grade: _________

COMPLETE ONLY IF ABOVE IS AN ADULT:

Your SS #:_____________________ Driver's Lic. #:______________________

DOB: ____

Employer's name: ____

Employer's street or box #:____

City/St./Zip: ____

How long:_____________________ Bus. phone: _______________________

If married, Spouse's name:____

DOB:____

Bus. phone: ___________________ How long:__________________________

SS#:__________________________ Driver's lic. #: ______________________

Employer's name: ____

Employer's street or box #:____

City/St./Zip: ____

MEDICAL HISTORY

Is the patient under the care of a physician for a specific problem at the present time? _____ Yes _____No

List any current medications being taken ____

List any allergies or drug sensitivities ____

Is there a history of serious illness, accident or operation? ____

Other than parent, person to notify in case of emergency ____ Phone # ___________________________

PLEASE CHECK THE FOLLOWING AS THEY APPLY

___ AIDS
___ Allergies / asthma
___ Arthritis
___ Bleeding problems
___ Diabetes
___ Ear infections
___ Emotional problems
___ Endocrine problems
___ Epilepsy
___ Glaucoma
___ Head or facial injury
___ Hearing problems
___ Heart trouble
___ Hepatitis/liver disease
___ High blood pressure
___ Kidney problems
___ Nerve problems
___ Rheumatic fever
___ Tonsillitis

DENTAL HISTORY

_____ yes _____ no Have there been any injuries to the face, mouth, or teeth? ____

_____ yes _____ no Has patient ever sucked thumb or finger? ____

_____ yes _____ no Have you been informed of any missing or extra permanent teeth? ____

_____ yes _____ no Has an orthodontist been consulted previously? ____

_____ yes _____ no Has patient had any previous orthodontic treatment? If so, by whom ____

Reason for seeking orthodontic treatment____

Additional information which you feel would make your association with us more enjoyable ____

Signature ____ Date _____________________________________

(IF UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN SIGNATURE)