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

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)