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Specialist in Orthodontics

Member American Association of Orthodontists

DIPLOMATE
AMERICAN BOARD
OF ORTHODONTICS

Welcome to our office! We are honored that you have chosen us to care for your child and we look forward to serving you. It is our desire to address your concerns about your son's or daughter's bite problem (or "malocclusion") during your first visit, which we call the examination.

This information acquaintance form will allow us to know more about your child. In our office, we want to treat your child first and his or her teeth second.

PERSONAL INFORMATION

Today's Date: / /

Patient's Name: _____
Last Name First Name Middle Name your child likes to be called

Date of Birth: / / Age: _____ yrs. _____ mos. Sex: _____ Grade: _____

Home Address: _____ Phone: _____
Street City Zip

Patient's Dentist: _____ Patient's Doctor: _____

Were you referred to us?.....YES ☐ NO ☐ If YES, by whom? _____

Does your child want orthodontic treatment?..... YES ☐ NO ☐

MEDICAL HISTORY

Has your child ever had:

Heart Trouble..... YES ☐ NO ☐	Glaucoma.....YES ☐ NO ☐	Broken Bones..... YES ☐ NO ☐
Liver Trouble.....YES ☐ NO ☐	Convulsions.....YES ☐ NO ☐	Diabetes..... YES ☐ NO ☐
Bleeding Problems..... YES ☐ NO ☐	Contact Lenses....YES ☐ NO ☐	Rheumatic Fever.....YES ☐ NO ☐
Hay Fever, Asthma,.....YES ☐ NO ☐ or Allergies	Tonsilitis.....YES ☐ NO ☐	Positive HIV test.....YES ☐ NO ☐

Is your child in good health now?.....YES ☐ NO ☐

Has your child ever had another serious illness, accident or condition?..... YES ☐ NO ☐

If YES, please list: _____

List any drugs or medications now being taken: _____

List allergies to any drugs or medication: _____

Has your child's tonsils or adenoids been removed?.....YES ☐ NO ☐

If YES, at what age? _____

Have you noticed rapid growth in the last 6 months?.....YES ☐ NO ☐

Does your child snore at night?.....YES ☐ NO ☐

Does your child grind his or her teeth at night?.....YES ☐ NO ☐

Does your child breath predominantly through his or her mouth?.....YES ☐ NO ☐

Does your child have any missing or extra teeth?.....YES ☐ NO ☐

Has your child had any traumatic dental examinations?.....YES ☐ NO ☐

If YES, at what age? _____

Has your child had a previous orthodontic examination?.....YES ☐ NO ☐

When was your child's last dental examination? ____/____/____

Does your child's gums bleed when brushed?.....YES ☐ NO ☐

Has your child ever received a severe blow to the head or jaw?.....YES ☐ NO ☐

If YES, when? _____

Have any of your child's teeth needed to be removed by your dentist?.....YES ☐ NO ☐

How often does your child brush his or her teeth? _____

Does or did your child ever suck his or her fingers, lip or another object?.....YES ☐ NO ☐

If stopped, at what age? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____ # years employed _____

Spouse's Name

_____
Last First Middle

Spouse's
Employer _____

Occupation _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's ID/SS# _____

Employer _____ Group # _____

Insurance Company Name: _____ Phone # _____

Insurance Company Address: _____

_____

Emergency Contact Information

Emergency Contact Name: _____

Phone # _____

I hereby agree that, to the best of my knowledge, the above information is true.

_____ _____
Signature **Date**