Orthodontic Acquaintance

PERSONAL INFORMATION

Patient's Name: _____ Phone Number: _____

Address: _____ Name of Family Physician: _____

Information for Patients Who Are MINORS:

School: _____ Grade: _____

Parent/Guardian: Father: _____ Mother: _____

Occupation: _____ _____

Business Phone: _____ _____

Parent's Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Information for ADULT Patients

Business Address: _____ Name of Spouse: _____

Marital Status: _____ Spouses Occupation: _____

Occupation: _____ Business Phone: _____

Business Phone: _____ _____

Person responsible for payment of account: _____ Is patient covered by orthodontic insurance? ❑ Yes ❑ No

MEDICAL HISTORY

Is the patient in good health?	❑ Yes	❑ No	Reason: _____
Any major or unusual illnesses?	❑ Yes	❑ No	Explain: _____
Currently under physician's care?	❑ Yes	❑ No	Reason: _____
Currently taking medication?	❑ Yes	❑ No	List: _____
Allergies	❑ Yes	❑ No	List: _____
Drug Sensitivity	❑ Yes	❑ No	List: _____

Please Check if Patient Has or Had Any of the Following:

YES	NO		YES	NO		YES	NO	
❑	❑	Anemia	❑	❑	Heart Disease	❑	❑	Frequent Colds or Flu
❑	❑	Blood Disease	❑	❑	Tuberculosis	❑	❑	Tonsillitis
❑	❑	Prolonged Bleeding	❑	❑	Diabetes	❑	❑	Adenitis
❑	❑	Hepatitis	❑	❑	Endocrine Problems	❑	❑	Tonsils Removed - Age: _____
❑	❑	Are you in a risk group for AIDS?	❑	❑	Bone Disorders	❑	❑	Adenoids Removed - Age: _____
❑	❑	Jaundice	❑	❑	Epilepsy	❑	❑	Asthma
❑	❑	Rheumatic Fever	❑	❑	Oral Herpes	❑	❑	Mouthbreathing: While Awake? _____
								While Asleep? _____

Growth Information for Patients Under **16 Years of Age**

Father's Height: _____ Mother's Height: _____ Adopted? ❑ Yes ❑ No

Patient Resembles: ❑ Neither Parent ❑ Mother ❑ Father

Girls: Has she started menstruation? ❑ No ❑ Yes When? _____

Boys: Has his voice changed? ❑ No ❑ Yes When? _____

Names and Ages of Patient's Brothers and Sisters: _____

Have any had Orthodontic Treatment? ❑ No ❑ Yes When? _____

DENTAL HISTORY

YES	NO	
❑	❑	Has the patient had any severe head or face injuries? Explain:
❑	❑	Has the patient had a history of thumb sucking or finger sucking? Stopped?
❑	❑	Does the Patient play any musical (wind) instruments? What?
❑	❑	Has the patient consulted an orthodontist previously?
❑	❑	Has the patient had any previous orthodontic treatment?

PLEASE CHECK IF THERE IS A HISTORY OF

YES	NO		YES	NO		YES	NO	
❑	❑	Clenching Teeth	❑	❑	Headaches (more than normal)	❑	❑	Jaw Joint Popping
❑	❑	Grinding Teeth	❑	❑	Jaw Joint Soreness	❑	❑	Ringing in the Ears
❑	❑	Muscular Soreness Around Head and Neck	❑	❑	Jaw Joint Clicking			

Is there any other information that may be helpful? _____

Why are you seeking orthodontic consultation? _____

THANK YOU! Signed: _____ Date: _____