LET'S GET ACQUAINTED

Patient Information

Patient's Name _____ (Last / First / Middle) Prefers To Be Called (Nickname) _____

Sex: M ☐ F ☐ Birthdate _____ Age _____ Home Phone ( ) _____

Cell Phone ( ) _____ E-Mail _____

School _____ Grade _____ Sports/Hobbies _____

Residence _____ (Street / City / Zip)

Mailing Address (If Different) _____ (Street / City / Zip)

Any Anticipated Move Or Transfer? ☐ Yes ☐ No When? _____ Where? _____

Does The Patient Have Any Brothers And/Or Sisters ☐ Yes ☐ No Names And Ages _____

Who May We Thank For Referring You To Us? _____ Dentist _____

Oral Surgeon _____ Periodontist _____ Physician _____

Parent Information

Father's Name _____ (Last / First / Middle) ☐ Stepfather ☐ Guardian Birthdate _____

Occupation _____ Employer _____ No. Years Employed _____

Work Phone ( ) _____ Cell Phone ( ) _____ Soc. Sec. # _____

Residence (If Different) _____ (Street / City / State / Zip)

Mailing Address (If Different) _____ (Street / City / State / Zip)

How Long At This Address _____ Home Phone ( ) _____ E-mail _____

Previous Address (If Less Than 3 Years) _____ (Street / City / State / Zip)

Mother's Name _____ (Last / First / Middle) ☐ Stepmother ☐ Guardian Birthdate _____

Occupation _____ Employer _____ No. Years Employed _____

Work Phone ( ) _____ Cell Phone ( ) _____ Soc. Sec. # _____

Residence (If Different) _____ (Street / City / State / Zip) E -mail _____

Parents ☐ Single ☐ Married ☐ Widowed ☐ Remarried ☐ Child Adopted
☐ Separated ☐ Divorced If Separated Or Divorced, Who Has Custody? _____

Person Responsible For This Account _____ Relationship _____

Dental/Orthodontic Insurance Information

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone ( ) _____

Policy Owner's Name _____ Birthdate _____ Soc. Sec. # _____

Do You Have Dual Coverage? ☐ Yes ☐ No If Yes, Complete Below:

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone ( ) _____

Policy Owner's Name _____ Birthdate _____ Soc. Sec. # _____

Emergency Information

Name Of Nearest Relative Not Living With You _____ Relationship _____

Address _____ (Street / City / State / Zip)

Phone ( ) _____

(CONTINUED ON BACK)

Medical History

Is The Patient In Good Health? ☐ Yes ☐ No If No, Explain _____

Has The Patient Been Diagnosed Or Treated For Any Of The Following?

No	AIDS/HIV Virus	No	Bone Disorders	No	Epilepsy	No	Herpes
No	Allergies, Hay Fever, Sinus	No	Cancer Or Tumor	No	Fainting Or Dizziness	No	Tuberculosis (TB)
No	Arthritis	No	Diabetes	No	Handicaps/Disabilities	Other	_____
No	Asthma	No	Emotional	No	Heart Trouble (Or Murmur)		_____
No	Prolonged Bleeding	No	Endocrine (Thyroid)	No	Hepatitis (Jaundice)		_____

No Is The Patient Under A Physician's Care? If Yes, Explain _____

No Has The Patient Had Any Major Illness Or Surgery? If Yes, Explain _____

No Is The Patient Taking Any Drugs Or Medications? Taking _____ For _____

Taking _____ For _____ Taking _____ For _____

No Does the Patient Have A History Of Congenital Heart Disease, Infective Endocarditis, Or Surgery To Place Artiflcial Cardiac Valves?

No Has The Patient Ever Been Told That He/She Needs To Take Antibiotics (Premedication) For Dental Treatment Or Teeth Cleaning?

No Does The Patient Have Any Drug Sensitivities Or Drug Allergies? Please List _____

No Does The Patient Have An Allergy To Latex?

No Has The Patient's Tonsils Or Adenoids Been Removed? Tonsils-When?_____ Adenoids-When?_____

No Has The Patient Reached Puberty? _____

☐ Girl — If Menstruation Started, When? _____

☐ Boy — If Voice Has Changed Or Has He Started Shaving, When? _____

No Is The Patient In A Growth Spurt Now? Height _____ Weight _____

ANY OTHER MEDICAL PROBLEMS THAT I SHOULD BE AWARE OF? _____

For Females No Is The Patient Pregnant? Expected Delivery Date _____

Dental History

Date Of Last Dental Check-up _____ Date Of Last Cleaning And Flouride _____

Date Of Last X-Rays _____ Name Of Dentist _____

No Have There Been Any Injuries To The Face, Mouth, Teeth Or Chin? Explain _____

No Has The Patient Ever Sucked A Thumb Or Fingers? Until What Age? _____

No Does The Patient Have A Problem Breathing Through The Nose? (Does The Patient Mouth Breathe?) Explain _____

No Does The Patient Play A Musical Instrument? List _____

No Does The Patient Clench Or Grind Teeth? When? _____

No Does The Patient Have Any Difflculty In Chewing Or Swallowing? Explain _____

No Does The Patient Have Frequent Headaches, Neck Or Shoulder Pain? Explain _____

No Does The Patient Have Jaw Joint (TMJ/TMD) Pain Or Noises Upon Opening Or Closing The Mouth? Explain _____

No Has The Patient Been Informed Of Any Jaw Joint (TMJ/TMD) Problems? Explain _____

No Has The Patient Been Informed Of Any Existing Or Potential Periodontal (Gum, Bone Loss) Problems? Explain _____

No Has The Patient Been Informed Of Any Missing Or Extra Permanent Teeth? Explain _____

No Have The Patient's Wisdom Teeth Been Extracted? How Many? _____ When? _____

No Is Any Part Of The Patient's Mouth Sensitive To Temperature, Pressure, Food Or Drink? Explain _____

No Has An Orthodontist Been Consulted Previously? Who? _____ When? _____

No Have You Been Dissatisfled With Any Previous Dentist Or Orthodontist? Who? _____

No Does Anyone In Your Family Have A Similar Orthodontic Problem? Who? _____

No Has A Brother/Sister Or Either Parent Had Orthodontic Treatment? Who? _____ When? _____

No Has The Patient Ever Been Teased About The Appearance of His/Her Teeth? Explain _____

WHAT IS YOUR MAIN REASON FOR SEEKING ORTHODONTIC CARE? _____

I Understand That Appropriate Credit Bureau Reports May Be Obtained.

DATE _____ **PARENT'S SIGNATURE** _____