

CHILDREN'S ORTHODONTIC ACQUAINTANCE FORM

Date _____
Date of Birth _____

ABOUT YOUR CHILD

Patient's Name _____ Nickname _____ Age _____ Sex _____
Home Address _____ Phone (____) _____
City _____ Zip _____ School _____ Cell (____) _____
Special interests, sports or hobbies: _____
Siblings (names and ages) _____
Who many we thank for sending you to our office? _____

ABOUT YOU

Father: _____ D.O.B _____
Address _____
City _____ Zip _____
Occupation _____ Employer _____
Soc. Sec.# _____ Drivers Liscense _____
Person Responsible for Account _____

Mother: _____ D.O.B _____
Address _____
City _____ Zip _____
Occupation _____ Employer _____
Soc. Sec.# _____ Drivers License _____
Email _____

IF YOU HAVE ORTHODONTIC INSURANCE PLEASE FILL OUT THE INFORMATION BELOW:

DENTAL INSURANCE COMPANY #1

Dental Ins. Co: _____
Their phone #: _____
Group #: _____
This Dental Insurance is provided through:
Their name: _____
Relationship to child: _____
Their Soc. Sec. #: _____
Their Birth date: _____
Their Employer: _____

DENTAL INSURANCE COMPANY #2

Dental Ins. Co: _____
Their phone #: _____
Group #: _____
This Dental Insurance is provided through:
Their name: _____
Relationship to child: _____
Their Soc. Sec. #: _____
Their Birth date: _____
Their Employer: _____

DENTAL/MEDICAL HISTORY

Has your child had any of the following medical conditions or problems?

PLEASE CIRCLE:

Y N Heart Murmur	Y N Hemophilia	Y N Cancer
Y N Heart problems of any kind	Y N Bleeding problems	Y N Diabetes
Y N Convulsions / Epilepsy	Y N Hearing impairment	Y N HIV + / AIDS
Y N Hyperactive	Y N Any operations	Y N Rheumatic Fever
Y N Any stays in hospital	Y N Glaucoma	Y N Hepatitis

Are there any other medical conditions or problems relating to your child? Y N If yes please list: _____
Are you currently under the care of a physician? Y N
Child's Physician _____ City _____ Phone #: _____

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS Y N

If yes, please list: _____
Is your child taking any prescription Medications? Y N If yes, please list: _____

DOES YOUR CHILD NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N

Child's Dentist _____ City _____
Approximate date of last visit: _____

PLEASE CIRCLE:

Has there been any injuries to the face, mouth or teeth? Y N
Has your child ever sucked his / thumb or fingers? Y N Until what age? _____
Does your child have any speech problems? Y N
Is your child a mouth breather Y N
Has your child had tongue-thrust or speech therapy? Y N
Has your child ever been informed of any missing or extra teeth? Y N
Has an orthodontist been consulted previously? Y N Who? _____
Have you ever been told your child has TMJ (Temporomandibular Joint) problems? Y N
Does your child's jaw joint ever make noise (cracking or popping sounds) when chewing or yawning? N Y
Has your child's jaw ever locked open? Y N
When was the last dental care? _____
Interests ie. Sports, hobbies, etc. _____

WHAT DO YOU WANT ORTHODONTIC TREATMENT TO ACCOMPLISH: _____

I understand that the information that i have given is correct to the best of my knowledge, that it will be held in strictest of confidence, and it is my responsibility to inform this office of any change in my health status.

Patient's signature _____ Date _____