ORTHODONTIC ACQUAINTANCE SHEET

Patient Information

Patient Name _____
Address _____

City _____ State ____ Zip _____
Birthday _____ Age ____ Sex ____
Social Security # _____
School _____ Grade _____

Mother's Name _____ Address _____
phone _____
Employer _____ Address _____
phone _____
SS# _____

Father's Name _____ Address _____
phone _____
Employer _____ Address _____
phone _____
SS# _____

What Concerns Do You Have? _____

_____

_____

_____

_____

Please Turn Over Page > > > > >

Medical History

Is the Patient In Good Health ? (Y N) _____
Does the Patient Have a History of Major Illness? (Y N) _____
_____
Is The Patient Currently Under The Care Of A Physician? (Y N) For What?
_____
Does The Patient Have Tendency To Colds? (Y N), Sore Throats? (Y N), Ear Infections? (Y N)
Have Tonsils and Adenoids Been Removed? (Y N) What Age?_____
List Drugs and/or Medications Now Being Taken.
_____
List Any Allergies Or Drug Sensitivities
._____
How Much Has The Patient Grown In The Past 6 Months? _____
Girls Only: Has Menstruation Started (Y N) How Long Ago? _____
Boys Only: Has Voice Changed? (Y N) When? _____
Height _____ Weight _____

DENTAL HISTORY

Who Is Your General Dentist? _____
Have There Been Any Injuries To The Face Or Teeth? (Y N)
Has The Patient Ever Sucked A Thumb Or Fingers? (Y N) Until What Age? ____
Does The Patient Have Any Speech Problems? (Y N)
Does The Patient Receive Special Speech Help ? (Y N)
Name Of Teacher And School _____
Is The Patient A Mouth Breather? (Y N)
Have You Been Informed Of Any Missing Or Extra Teeth? (Y N)
Has Eather Parent Had Orthodontic Treatment ? (Y N)
List Any Musical Instruments Played. _____

Patient / Guardian Must Sign _____ Date _____