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? ______________________________

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Medical History

Is the Patient In Good Health ? (Y N) ____________________________
Does the Patient Have a History of Major Illness? (Y N) _____________
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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 _____