Acquaintance Form

Date ___________

Patient name (First) ____________ (Middle)____________ (Last)_____________ Name Called _______________

Home Address _______________________ City __________ State _____ Zip _____ Home Phone (___) ________

Sex ☐ M ☐ F Birth date ___ /_____ / ___ Age _______ General Dentist ______________________________

Friends or Relatives treated here ____________________________________ Referred By_________________

Medical History

Please check box if patient has or has had

- ☐ Joint Swelling
- ☐ Bone Disorders
- ☐ Heart Trouble
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Emotional Problems
- ☐ Brain Injury
- ☐ Kidney or Liver Involvement
- ☐ AIDS or AIDS Related Complex
- ☐ Allergies (please list) ________________________
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Prolonged Bleeding
- ☐ Faintness/Dizziness
- ☐ Tonsils Removed
- ☐ Adenoids Removed
- ☐ Sore Throats
- ☐ Tonsillitis
- ☐ Earaches

List any other serious or medical problems not listed above

Describe ___________________________________

____

____

List drugs or medications now being taken:

____

Is patient under physician's care presently? __________

Reason: ____________________________________

Name of Physician: ___________________________

Do you require antibiotic pre-medication prior to dental procedures?_________________________________

Please Check box if answer is yes:

- ☐ Any injuries to **face**, **mouth**, **teeth**? (circle)
- ☐ Mouth-breathing when asleep, awake? (circle)
- ☐ More than average amount of tooth decay?
- ☐ Any missing permanent teeth?
- ☐ Any extra permanent teeth?
- ☐ Visits dentist regularly?

Date of last dental visit _________ Cleaning ___________

☐ Has consulted an orthodontist previously:

Reason: ____________________________________

- ☐ Is this visit for a second opinion?
- ☐ Family history of underbite (strong lower jaw)
- ☐ History of thumb/finger sucking habit?
- ☐ Any history of speech therapy?
- ☐ Any difficulty in swallowing or chewing?
- ☐ Any pain or clicking when opening mouth?
- ☐ Adopted

Sports: ____________________________________

What about your smile would you like to see different?

____

Patient's attitude towards having orthodontics:
(circle one)
Want it done **Does Not Want** **Does not Care**

Father's Name

Mr. ☐ Dr. ☐ Rev. ☐ ______________________ Birth Date __ / ____ / ____ Marital Status_______________
(First) (Last)

Address _____________________ City ___________ State _____Zip ________Yrs. at this address_________

Cell Phone (___)________________ Email ____

Employer _____________________ Yrs. with this employer __ Occupation _________ Work phone (___) ________

Dental Insurance Carrier ___________________________________Carriers Phone (___) _______________

Group # ____ ID# ___________________________________

Mother's Name

Mrs. ☐ Ms. ☐ Rev. ☐ ______________________ Birth Date __ / ____ / ____ Marital Status_______________
(First) (Last)

Address _____________________ City ___________ State _____Zip ________Yrs. at this address_________

Cell Phone (___)________________ Email ____

Employer _____________________ Yrs. with this employer __ Occupation _________ Work phone (___) ________

Dental Insurance Carrier ___________________________________Carriers Phone (___) _______________

Group # ____ ID# ___________________________________