CHILD ORTHODONTIC ACQUAINTANCE CARD

Patient's name _____ Date _____ Date of birth _____ Age _____

Name patient goes by _____ School _____ Grade _____

Home address _____ City _____ Zip _____ Phone ( ) _____

Referred by _____ Have you seen another Orthodontist? _____

Patient's Dentist _____ Physician _____

Father's name _____ Address if different _____

Occupation _____ Employed By _____ Phone _____

Mother's name _____ Address if different _____

Occupation _____ Employed By _____ Phone _____

Responsible party _____ SSN _____ Dental Insurance _____

GENERAL APPRAISAL

What concerns you most about your child's teeth? _____

Other children with similar orthodontic problems and age _____

Parents or grandparents with similar problem _____

Has any member of your family received orthodontic treatment? _____

Patient cooperation will be: Excellent _____ Good _____ Fair _____ Poor _____ Indifferent _____

MEDICAL HISTORY

Is patient in good health? ☐Yes ☐No Does patient have any history of major illness? ☐Yes ☐No

Does patient have a tendency to: ☐Colds ☐Sore throats ☐Ear infections

Have tonsils and adenoids been removed? ☐Yes ☐No What age? _____

List any drugs or medications now being taken. Give reasons _____

List any allergies or drug sensitivity: _____

Has patient reached puberty? ☐Yes ☐No Girls - Has she started menstruation? ☐Yes ☐No Boys - Has his voice changed? ☐Yes ☐No

Is there any past or present history of the following?

Rheumatic Fever	☐Yes ☐No	Persistent Headaches	☐Yes ☐No	Heart Murmur	☐Yes ☐No
Neck Pains	☐Yes ☐No	Nerve or Brain Disease	☐Yes ☐No	High Blood Pressure	☐Yes ☐No
Migraine	☐Yes ☐No	Heart Attack/Stroke	☐Yes ☐No	Blood Vessel Disease	☐Yes ☐No
Epilepsy	☐Yes ☐No	Blood Disorder	☐Yes ☐No	Mental Health Problems	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Bone Disorders	☐Yes ☐No	Arthritis (Any type)	☐Yes ☐No
Hepatitis	☐Yes ☐No	Gout	☐Yes ☐No	Diabetes	☐Yes ☐No
Ear Disorder	☐Yes ☐No	Ulcers	☐Yes ☐No	Sinus Infection	☐Yes ☐No
Herpes (Any type)	☐Yes ☐No	Swollen Glands	☐Yes ☐No	Psoriasis	☐Yes ☐No
Allergies	☐Yes ☐No	Cancer	☐Yes ☐No	Other _____	

DENTAL HISTORY

Have there been any injuries to face, mouth, or teeth? ☐Yes ☐No Has patient ever sucked thumb or fingers? ☐Yes ☐No Until what age? ____

Has the patient ever been treated for periodontal (gum) disease? ☐Yes ☐No

Does the patient have any speech problems? ☐Yes ☐No Is the patient a mouth breather? ☐Yes ☐No ☐While awake? ☐While asleep?

Have you been informed of any missing or extra permanent teeth? ☐Yes ☐No

List any musical instruments played _____

MVC5/00

Parent's Signature _____