Smiles by Dr.W & Dr.R

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Quality Orthodontics That Will Make You Smile

Orthodontic Acquaintance Form

Patient's Name: _____ Sex: ☐ Male ☐ Female Birthdate _____
Street: _____ City: _____ State: _____ Zip: _____
Telephone: Home: _____ Cell: _____ Office: _____
Social Security #: _____ Employer: _____
Email Address: _____

Father (Husband): _____ Marital Status: _____
Employer: _____ Occupation/Position: _____
Social Security #: _____ Business Phone: _____
Cell Phone: _____

Mother (Wife) _____ Marital Status: _____
Employer: _____ Occupation/Position: _____
Social Security #: _____ Business Phone: _____
Cell Phone: _____

Name and age of other family members:

Name	Birthdate
_____	_____
_____	_____
_____	_____
_____	_____

PERSON RESPONSIBLE FOR ACCOUNT: FATHER MOTHER SELF OTHER
If Other:
Name: _____ Relation: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

DENTAL INSURANCE Insured S.S. # : _____
Name of Insured: _____ Employer: _____
Insured's Date of Birth: _____ Group/Plan #: _____
Insurance Company: _____ Telephone #: _____

Emergency contact (other than parent/spouse):
Name: _____ Phone #: _____ Relationship to patient: _____
Patient's Dentist: _____
Patient's Physician: _____

Whom may we thank for referring you? _____

What are the main concerns regarding the patient's jaws and teeth?

☐ Crowding	☐ Prominent jaw	☐ Missing teeth	☐ Irregularly shaped teeth	☐ No concerns at all
☐ Over-bite	☐ Gummy smile	☐ Jaw dysfunction	☐ Protrusion of teeth	☐ Other: _____
☐ "Buck" teeth	☐ Spaces	☐ Mouth too small	☐ Poor facial proportions	
☐ Receded jaw	☐ Gum disease	☐ Clicking jaw joint	☐ Headaches/facial pain	

MEDICAL / DENTAL HISTORY

1) *Present health* good fair poor
   a) Physical ☐ ☐ ☐
   b) Emotional ☐ ☐ ☐
   c) If a child; has patient reached puberty? ☐ Yes ☐ No

2) *Are there any learning issues* (ADD, ADHD, etc.)
   ☐ Yes ☐ No

3) *Has the patient ever had any of the following conditions?*
   ☐ Aids
   ☐ Allergies (seasonal/environmental)
   ☐ Arteriosclerosis
   ☐ Asthma
   ☐ Autoimmune disorder
   ☐ Blood disease
   ☐ High blood pressure
   ☐ Low blood pressure
   ☐ Bone disorder
   ☐ Cancer
   ☐ Diabetes
   ☐ Dizziness
   ☐ Other_____
   ☐ Epilepsy
   ☐ Endocrine problems
   ☐ Emotional problems
   ☐ Female problems
   ☐ Hepatitis
   ☐ Heart disease
   ☐ Hearing disorder
   ☐ Kidney disorder
   ☐ Rheumatic fever
   ☐ Ringing in ears
   ☐ Sleep disturbance
   ☐ Received trauma (teeth, face, jaws, or head)

4) *MEDICATIONS: Current patient medications:*
   ☐ Heart medications _____
   ☐ Antibiotics_____
   ☐ Diet pills (diuretics)
   ☐ Ritalin, Concerta, Adderal, etc.
   ☐ Vitamins
   ☐ Aspirin therapy
   ☐ Birth control pills
   ☐ Sleeping pills
   ☐ Muscle relaxants
   ☐ Insulin
   ☐ Coumadin
   ☐ Other_____

   Need to premedicate for dental work? ☐ yes ☐ no

5) *ALLERGIES: The patient demonstrates an allergic response to:*
   ☐ Antibiotics_____
   ☐ Pain pills (codeine, etc.) _____
   ☐ Dairy products
   ☐ Wheat, cereals
   ☐ Dyes in food
   ☐ Latex
   ☐ Other _____

6) *Do any of the following apply to the patient:*
   a) Snore when sleeping?
      ☐ Yes ☐ No
   b) Breathe through the mouth?
      (mouth breather vs. nose breather)
      ☐ Seldom ☐ Sometimes ☐ Usually
   c) Frequent colds?
      ☐ Yes ☐ No
   d) Frequent sore throats or tonsillitis?
      ☐ Yes ☐ No
   e) Difficulty swallowing?
      ☐ Yes ☐ No
   f) Difficulty chewing?
      ☐ Yes ☐ No
   g) Pain or clicking in the jaw joints?
      ☐ Yes ☐ No
   h) Speech problems?
      ☐ Yes ☐ No

7) *Does the patient have any of the following habits?*
   a) Thumb sucking:
      ☐ never ☐ previously ☐ presently
   b) Finger sucking:
      ☐ never ☐ previously ☐ presently
   c) Lip biting or sucking
      ☐ No ☐ Yes
   d) Grinding of teeth:
      ☐ No ☐ Yes
   e) Tongue thrusting:
      ☐ No ☐ Yes
   f) Other habits: _____

PATIENT OR PARENT ATTITUDE REGARDING DENTAL CARE AND TREATMENT

1) *Dental Checkups*
   ☐ Twice a year ☐ Only if urgent
   ☐ Once a year ☐ Never

2) *Any unusual dental experience?* ☐ Yes ☐ No
   _____
   _____

3) *Aware of any orthodontic problems?*
   ☐ Yes ☐ No

4) *Interest in orthodontic treatment:*
   ☐ Wants treatment ☐ Treatment if necessary
   ☐ Unwilling but agree ☐ Uncooperative

5) *Orthodontic consultation prompted by.*
   ☐ Patient ☐ Spouse ☐ Dentist
   ☐ Sibling ☐ Mother ☐ Physician
   ☐ Father ☐ Friend

6) *Previous orthodontic consultation or treatment?*
   ☐ Yes ☐ No

7) *Are there any medical, dental, or surgical problems not covered above?* ☐ Yes ☐ No
   _____
   _____

NO PROTECTED PATIENT INFORMATION SHALL BE USED OR DISCLOSED IN ANY MANNER OTHER THAN IN CONFORMITY WITH HIPAA ACT OF 1996. OUR OFFICE POLICY IS AVAILABLE FROM OUR OFFICE MANAGER FOR YOU TO REVIEW.

_____
Signature (patient or responsible adult)