

ADOLESCENT ORTHODONTIC ACQUAINTANCE CARD

Patient's Name:				Date:	
Last	First	Middle Initial	Nickname		
Birthdate:	Age:	Sex:	School:	Grade:	
Address:					
City:		St:	Zip:	Home Phone()	-
Patient's Dentist:			Referred by:		
Father/Guardian's Name:				Birthdate:	
Address(if different):				Cell Phone()	
Employed by:		Position Held:		Soc.Sec.#	- -
Business Address:				Bus.Phone()	
Mother/Guardian's Name:				Birthdate:	
Address(if different):				Cell Phone()	
Employed by:		Position Held:		Soc.Sec.#	- -
Business Address:				Bus.Phone()	
Is Patient Adopted? (circle one) Yes or No			Person Responsible for Account:		
Names and Ages of Other Children in Family:					

MEDICAL HISTORY

Is patient in good health? (circle one) Yes or No

Does patient have any history of major illness? Yes or No

Is the patient presently under the care of a physician for a major illness? Yes or No Physician name:

Please list the major illness:

Check any of the following for which the patient has been treated:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Cancer/Chemotherapy |
| <input type="checkbox"/> Heart Trouble/Abnormalities | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Artificial Joints / Valves |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Psychiatric problems |

Does patient have a tendency to colds? Yes or No Sore throats? Yes or No Ear infections? Yes or No

Have the tonsils and adenoids been removed? Yes or No If Yes, at what age?

List any drugs or medications now being taken and reasons being taken:

List any allergies or drug sensitivity:

Has the patient reached puberty? Yes or No Boys- has voice changed? Yes or No

Girls- started menstruation? Yes or No If Yes, at what age?

Height: Weight:

DENTAL HISTORY

Have there been injuries to the face? Yes or No Mouth? Yes or No Teeth? Yes or No

Has the patient ever sucked a thumb or fingers? Yes or No Until what age?

Does the patient have any speech problems? Yes or No

Is the patient a mouth breather? Yes or No While awake? Yes or No While asleep? Yes or No

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

Has an orthodontist been consulted previously? Yes or No

What are the main concerns that you would like orthodontic treatment to address?

Parent or Patient Signature