ORTHODONTIC AQUAINTANCE FORM

Date ________________

Demographic Information

Patient's Name ____ Name they would like to be called ____________________

Age ______ Birth date ________________ Social Security Number ____________________________ Sex (Circle one) F M

Address ____
Street City State Zip Code

Home Phone Number ____________________ Names & ages of siblings ____

Mother's Name _______________________________________ Social Security # ____________________ DOB __________

Mother's Employer ____________________________ Work Phone # ________________ Mobile Phone # ________________

Father's Name _______________________________________ Social Security # ____________________ DOB __________

Father's Employer ____________________________ Work Phone # ________________ Mobile Phone # ________________

Who has legal custody of patient? ________________________ Patient lives with: Mother Father Both Other ____________

Child's Physician ___________________________________ Phone # _______________ Date of last exam _______________

Child's Dentist _____________________________________ Phone # _______________ Date of last exam _______________

Whom may we thank for referring you to us? ____

Please provide your email address if you would like to receive your appointment confirmations by email:

Email Address: ____ (Mother / Father / Other_____________)

YES NO

Health History

___ ___ Has your child ever had a health problem? Please explain____

___ ___ Has your child ever been hospitalized? Please give reason and dates___________________________________

___ ___ Is your child allergic to anything? ____

___ ___ Is your child currently taking any medications? Please give medication and reason ______________________

___ ___ Were there any problems at birth? ____

Please check if your child has been treated for any of the following:

___ Heart disease ___ Liver disease ___ Kidney disease ___ Anemia ___ Bleeding/transfusion
___ Asthma ___ Rheumatic fever ___ Seizures ___ Diabetes ___ Hepatitis
___ Cerebral palsy ___ Cleft lip/palate ___ AIDS ___ Depression ___ ADHD/ADD
___ Learning Disability ___ Speech/hearing ___ Other Problems (Please explain) ______________________________

Reason for orthodontic consultation? ____

YES NO

Dental History

___ ___ Has an orthodontist been consulted previously? Name ____

___ ___ Have you been informed of any missing or extra permanent teeth? ___________________________________

___ ___ Have there been injuries to the face, mouth, or teeth? ____

___ ___ Does your child have pain with chewing, yawning or wide opening? __________________________________

___ ___ Does your child's jaw make noise and is pain associated with the sounds? ____________________________

___ ___ Has either parent had orthodontic treatment? ____

YES NO

Growth Data

___ ___ Do your feel your child is still actively growing?

___ ___ Females: Has menstruation started? What age: _____________

___ ___ Males: Has there been a voice change or change in facial hair? ______________________________________

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I understand that it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize Dr. Christensen and the dental staff of Durham PDO to perform any necessary dental services that are needed during diagnosis and treatment, including orthodontic records (models, photographs, and radiographs.) I understand that these records may be used for both diagnostic and educational purposes.

Signature ________________________________ **Relationship to patient** ________________ **Date**__________

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