ORTHODONTIC AQUAINTANCE FORM

Date _____

Demographic Information

Patient's Name _____ Name they would like to be called _____

Age _____ Birth date _____ Patient's Mobile Phone # (___)_____ Sex (Circle one) F M

Address _____
Street City State Zip Code

Home Phone Number _____ Names & ages of siblings _____

Parent 1's Name _____ Social Security # _____ DOB _____

Parent 1's Employer _____ Work Phone # (___)_____ Mobile Phone # (___)_____

Parent 2's Name _____ Social Security # _____ DOB _____

Parent 2's Employer _____ Work Phone # (___)_____ Mobile Phone # (___)_____

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

Please provide the email address(es) of those who would like to receive appointment confirmation emails:

Email Address: _____ (Mother / Father / Other_____)

Email Address: _____ (Mother / Father / Other_____)

Child's Physician _____ Phone # (___)_____ Date of last exam _____

Child's Dentist _____ Phone # (___)_____ Date of last exam _____

How did you hear about our office: ☐ Internet/Website ☐ Friend_____ ☐ Physician/Dentist_____ ☐ Other _____

What concerns do you have about your child's teeth? _____

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Health History

YES	NO	
___	___	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) _____		

Dental History

YES	NO	
___	___	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? _____

Growth Data

YES	NO	
___	___	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**_____

DURHAM PEDIATRIC DENTISTRY & ORTHODONTICS
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