ORTHODONTIC AQUAINTANCE FORM

Date ___________________

Demographic Information

Patient's Name ____ Birth Date _________________ Age ___________

Name they would like to be called _________________ Sex (Circle one) F M Other Patient's Phone # (____)__________

Address ____
(Street) (City) (State) (Zip Code)

Home Phone # (____)______________ Names & Ages of Siblings ____

Parent 1's Name ____________________________________ Social Security # _____________________ DOB __________

Parent 1's Employer ____________________________ Work Ph. # (____)_____________ Mobile # (____)______________

Parent 2's Name ____________________________________ Social Security # _____________________ DOB __________

Parent 2's Employer ____________________________ Work Ph. # (____)_____________Mobile # (____)______________

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 Search ☐ Website ☐ Facebook ☐ Instagram ☐ Magazine Ad
☐ Physician or Dentist______________ ☐ Parent in our practice______________ ☐ Other_______________

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

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:

___ ADHD	___ Bleeding/Transfusion	___ Respiratory Problems	___ Speech Problems	___ Other Skin Problems
___ Autism Spectrum	___ Heart Disease	___ Diabetes	___ Vision Problems	___ Canker Sores
___ Anxiety	___ Heart Murmur	___ Gland Problems	___ Cerebral Palsy	___ Cleft Lip/Palate
___ Behavioral Issues	___ Hepatitis A, B or C	___ Growth Issues	___ Epilepsy/Seizures	___ Cold Sores
___ Depression	___ High Blood Pressure	___ Thyroid Disorder	___ Headaches	___ Eating Disorders
___ Learning Differences	___ Rheumatic Fever	___ Bladder/Kidney	___ Neurological Problems	___ Frequent Infections
___ Psychiatric Problems	___ Sickle Cell	___ Liver Disease	___ Muscular Disorder	___ Stomach Problems
___ AIDS	___ Asthma	___ Cancer	___ Joint Problems	___ Ulcer
___ Anemia	___ Cystic Fibrosis	___ Hearing Problems	___ Eczema/Psoriasis	___ Other ____________

Does your child have any disease, condition, syndrome or issue not listed here? ____

Do you consider your child to be: ___ Advanced ___ Progressing Normally ___ Delayed ___ Other _______________

Adolescents: ___ STD ___ Substance Abuse, Alcoholism, Drug Addiction ___ Pregnancy or Nursing ___ Tobacco Use

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? ____

___ ___ Does your child suck a: ☐ Thumb ☐ Finger(s) ☐ Pacifier ☐ Other _________________

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

Please check if your child is currently having problems with any of the following:

___ Cavities ___ Toothache ___ Sensitive Teeth ___ Color of Teeth ___ Trauma ___ Gum Infections

___ Crowded or Crooked Teeth ___ Eruption Problems ___ Pain with Chewing ___ Grinding Teeth ___ TMJ Pain

___Jaw or Joint Noise ___ Other ____

YES NO

Fluoride History

___ ___ Is your drinking water fluoridated? (Your water is fluoridated if you pay a "City of Durham" or "OWASA" water bill.)

___ ___ Do you use well water in your home? If yes, has it been analyzed for fluoride? (Circle one) Yes / No

___ ___ Does your child use a fluoride toothpaste?

___ ___ Do you give your child any other form of fluoride? What? ____

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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Consent of Dental Treatment

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, his associates and the dental staff of Durham PDO to perform any necessary dental services that are needed during diagnosis and treatment including orthodontic records (models and radiographs.) I understand that these records may be used for both diagnostic and educational purposes. I will allow photographs to be taken of my child and my child's teeth, for diagnostic & academic purposes.

I understand that dental treatment for young children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentists will provide an environment to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments.

Signature _________________________________ Date__________

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Payment Policy

I will be responsible for any charges incurred for my child's dental treatment. I understand that by failing to make payments to Durham Pediatric Dentistry & Orthodontics my account can be turned over to a collection agency. Durham Pediatric Dentistry & Orthodontics will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature _________________________________ Date__________

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Notice of Privacy Practices

I have been provided with Durham Pediatric Dentistry & Orthodontics' Notice of Privacy Practices that provides a complete description of their policy on the use and disclosure of protected health information.

Signature _________________________________ Date__________
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