

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: Name (Mr.,Mrs.,Ms.,Dr.) _____ Social Security # _____ DOB _____

Parent #1 Employer _____ Work Ph. # (____) _____ Mobile # (____) _____

Parent #2 Name (Mr.,Mrs.,Ms.,Dr.) _____ Social Security # _____ DOB _____

Parent #2 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? _____

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? _____

____ Will someone other than a legal guardian be bringing your child to their appointments? _____

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? _____
- ___ ___ Does your child snore during sleep or stop breathing during sleep? _____
- ___ ___ 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 you 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? _____

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 _____

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 _____

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 _____