Patient Acquaintance Card

Today's Date___/___/___

Patient Information

Name____Preferred name__________________age______ Sex_______
Last First Initial
Date of Birth___/___/___

Home Address: ____
Street City State Zip

Phone:(H)____________ (W)____________ (C)____________ email_________________________________
Single__________ Married__________ Divorced__________ Separated_________ Widowed__________
Dentist's name_____________________________________
Who suggested that you might need orthodontic treatment?_____________________________________
Why did you select this office? ____
Do you have orthodontic benefits? _______ If so, company name:________________________________
Who is the financially responsible for this account?__________________________ __________________________
Names and ages of other children in the family (please indicate if any are currently patients in this office):_______________
____

Medical History

Are you in good health?_______ Height_____ft_____in Weight_______lb
Do you have a history of major illness?______________________________ Physician_________________________
List current medications and reason for taking them: ____
____
List any known drug, latex or other allergies/sensitivities:____

Do you smoke or use tobacco?______________ Drink coffee/tea?______________
Female: Have you ceased menstruation?_____ If yes, when?____________________
Have you taken/are you taking hormone replacement therapy? ____________

Check any of the following for which you have been treated:

___Diabetes	___Anemia	___Bleeding Disorder	___Heart Disease
___Pneumonia	___Tuberculosis	___Rheumatic Fever	___Kidney Disease
___Epilepsy/Seizures	___Fainting/Dizziness	___Nervous Disorders	___ADHD
___Bone Disorders	___Asthma	___Hepatitis	___HIV/AIDS

Dental History

When was your last dental checkup?______________________ Last cleaning ?______________________________
Have/do you ever had a thumb or finger sucking habit?_______ If yes, until what age?__________________________
Do you have any speech problems? _______________________ Are you a mouth breather? ______________________
Have you been informed of any missing or extra permanent teeth? ____
What is your main reason for this orthodontic examination? _________ ____
Have you seen an orthodontist prior to this visit for a consult?________ If yes, when_____________ where_ _____________
Have you had orthodontic treatment previously?_______ If yes, when_____________ where_____________ _____________
Do you prefer a specific type of braces? silver (standard) _________clear _________gold _________ Invisalign___________
Have you been seen by a periodontist?________ If yes, when_____________ where_ _______________________________
Is your orthodontic examination part of a restorative treatment plan (crowns, bridges, implants, dentures) that you have discussed with your dentist?____