



Patient Acquaintance Card

Patient Information

Date ____ / ____ / ____

Name _____ Preferred Name _____ Age _____ Sex _____
Last First Initial Date of Birth ____ / ____ / ____

Home Address: _____
Street City State Zip

Phone: (H) (____) (C) (____) Email: _____

School _____ Grade _____ Favorite Hobby _____

Do you have orthodontic benefit? _____ If so, company name: _____

Who is financially responsible for this account? _____ SSN _____

Parents' Information

Father

Mother

Name	_____	_____
Home Address	_____	_____
Phone (HM & Cell)	_____	_____
Occupation & Employer	_____	_____
Work Phone	_____	_____
Work Address	_____	_____

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 reasons for taking them: _____

Allergies: List any known drug, latex or other allergies / sensitivities: _____

Do you smoke or use tobacco? _____ Drink coffee / tea? _____

Have you reached puberty? _____ Female: Started Menstruation? _____ If yes, when? _____

Male: Voice Changed? _____ If yes, when? _____

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

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Fainting / Dizziness	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> ADHD
<input type="checkbox"/> Bone Disorders	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV / AIDS

Dental History

Who is your dentist? _____

When was your last dental checkup? _____ Last Cleaning / Prophylaxis? _____

Have you ever had a thumb or finger sucking habit? _____ If yes, until what age? _____

Have you had orthodontic treatment previously? _____ If yes, when? _____ Where? _____

Do you have any speech problems? _____ Are you a mouth breather? _____

Signature: _____ Date: _____

Doctor Signature: _____ Date: _____