Orthodontic Acquaintance Card

(Please Print)

Patients Name:_____ Date:_____

Birthdate:_____ Age:_____ M / F

Mailing Address:_____ Parents Email:_____

City:_____ State:_____ Zip:_____

Father's Name:_____ DOB:_____ SSN:_____

Mailing Address:_____ City:_____ Zip:_____

Employer:_____ Work Phone:_____

Cell Phone:_____ Provider:_____

Mother's Name:_____ DOB:_____ SSN:_____

Mailing Address:_____ City:_____ Zip:_____

Employer:_____ Work Phone:_____

Cell Phone:_____ Provider:_____

Person Responsible For Payment:_____ DOB:_____ SSN:_____

Employer:_____ Work Phone:_____

**I acknowledge that I am financially responsible for all charges. Any balance not paid by insurance will be my responsibility as will be any fee connected with a non-paying account including attorney fees and collection expenses.

Signature:_____ Date:_____

Why did you seek this orthodontic consultation?_____

Who referred you?_____ Have you seen an orthodontist before? Y / N

Relatives or friends treated here:_____

Does your insurance cover orthodontics? Y / N Employee Name:_____ DOB:_____

Insurance Company:_____ ID #:_____ Group #:_____

Secondary Insurance:_____ ID #:_____ Group #:_____

Policy Holder:_____ DOB:_____ SSN:_____

MEDICAL HISTORY

Physician:_____

Is the patient in good health? Y / N

Has the patient seen a physician in the last 2 years? Y / N

What was the reason?_____

_____

List any drugs or medications now being taken:_____

_____

List any allergies or drug sensitivity:_____

_____

Does the patient wear contact lenses: Y / N

Please circle all that apply:

HIV	Hepatitis
Diabetes	Glaucoma
Heart Trouble	High Blood Pressure
Rheumatic Fever	Prolonged Bleeding
Bone Disorders	Fainting/Dizziness
Thyroid Disorders	Epilepsy
Anemia	Asthma
Arthritis	Head & Neck Pain
None of the above	Other:_____

DENTAL HISTORY

Family Dentist:_____

Date of last dental cleaning/exam:_____

Has the patient noticed or been told of:

Thumb/finger sucking	Y / N
Tongue thrusting	Y / N
Popping/Clicking/Pain of jaw joint	Y / N
Mouth Breathing	Y / N
Teeth grinding/clenching	Y / N
Missing or extra permanent teeth	Y / N
Ear infection	Y / N
Gum disease	Y / N

Have any permanent teeth been injured by a fall or blow? Y / N

Have tonsils and adenoids been removed? Y / N

Have any primary or permanent teeth been removed? Y / N

PATIENT PROFILE

Does the patient follow directions well? Y / N

Does the patient brush his/her teeth? Y / N

Does patient have learning disability or need help with instructions? Y / N