Orthodontic Acquaintance Card

(Please Print)

Account # _____

Patient's Name _____ SS# _____ Date _____

Nickname _____ Sex _____ Age _____ Birthdate _____

Address _____ e-mail _____

City _____ Zip _____ Home Phone _____ Cell _____

Employed By _____ Work Phone _____ Cell _____

Spouse's Name _____ DOB _____ SS# _____

Employed By _____ Work Phone _____ Cell _____

Person responsible for payment _____ DOB _____ SS# _____

Address _____ City _____ Zip _____

Employed by _____ 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 reffered you? _____

Have you been examined by an orthodontist before? _____

Is the patient interested in having orthodontic treatment? Yes ☐ No ☐

Relatives or friends treated here _____

Does your insurance cover orthodontics? Yes ☐ No ☐ Subscriber Name _____

Insurance Company _____ Group # _____ ID # _____

Does your insurance cover orthodontics? Yes ☐ No ☐ Subscriber Name _____

Insurance Company _____ Group # _____ ID # _____

MEDICAL HISTORY

Family Physician _____

Is the patient in good health Yes ☐ No ☐

Has the patient seen a physician in the last 2 years Yes ☐ No ☐

What was the reason for the visit _____

_____

List any drugs or medications now being taken _____

_____

List any allergies or drug sensitivity _____

_____

Does the Patient wear contact lenses Yes ☐ No ☐

Check all of the following:					
HIV	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Heart trouble	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Prolonged bleeding	Yes ☐	No ☐
Bone disorders	Yes ☐	No ☐	Fainting/dizziness	Yes ☐	No ☐
Thyroid disorders	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Head & neck pain	Yes ☐	No ☐
			Tuberculosis	Yes ☐	No ☐

DENTAL HISTORY

Family Dentist _____

Date of Last dental examination _____

Has the patient noticed or been told of:

Thumb/Finger sucking	Yes ☐	No ☐
Tongue thrusting	Yes ☐	No ☐
Popping/Clicking/pain of jaw joint	Yes ☐	No ☐
Mouth Breathing	Yes ☐	No ☐
Teeth grinding/clenching	Yes ☐	No ☐
Missing or extra permanent teeth	Yes ☐	No ☐
Ear infection	Yes ☐	No ☐
Gum disease	Yes ☐	No ☐

Have any permanent teeth been injured by a fall or blow	Yes ☐	No ☐
Have Tonsils and adenoids been removed	Yes ☐	No ☐
Have any primary or permanent teeth been extracted	Yes ☐	No ☐