Orthodontic Acquaintance Card

(Please Print)

Account # _____

Patient's Name _____ Date _____

Nickname _____ Sex _____ Age _____ Birthdate _____

Address _____ e-mail _____

City _____ Zip _____ Home Phone _____ Cell _____

Father's Name _____ DOB _____ SS# _____

Address _____ City _____ Zip _____

Employed By _____ Work Phone _____ Cell _____

Mother's Name _____ DOB _____ SS# _____

Address _____ City _____ Zip _____

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? _____

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 ☐		

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 ☐

PATIENT PROFILE

Does patient follow directions well Yes ☐ No ☐

Does patient brush his/her teeth Yes ☐ No ☐

Does patient have learning disability or need help with instructions

Yes ☐ No ☐