

ORTHODONTIC ACQUAINTANCE FORM

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Patient's Information

First Name _____ Last Name _____ Prefers to be called _____ Birthdate ____/____/____
Home Address _____ How long _____ Apt. # _____ Phone (____) _____
City _____ Zip _____ School _____ Grade _____
Special interests, sports or hobbies _____
e-mail address _____
Sibling names and birthdates _____

Father's Information

Father's Name _____ Father's S.S.# _____ Home phone (____) _____
Employer _____ Position _____ How long _____ Work # (____) _____
Work Address: _____ City _____ State _____ Zip _____
Address (if different than patient's) _____ City _____ Zip _____

Mother's Information

Mother's Name _____ Mother's S.S.# _____ Home phone (____) _____
Employer _____ Position _____ How long _____ Work # (____) _____
Work Address: _____ City _____ State _____ Zip _____
Address (if different than patient's) _____ City _____ Zip _____

Who is the best person to contact regarding treatment? _____ To schedule appointments? _____
When and where are the best times to make contact? _____

Person Responsible For Account

Mother Father Other...First Name _____ Last Name _____ Relationship _____
Home Address _____ City _____ State _____ Zip _____
How long at this address _____ Home phone (____) _____ S. S. # _____
Former Address(if less than 3 years) _____ City _____ State _____ Zip _____
Employer _____ Position _____ How long _____ Work # (____) _____
Do you have orthodontic insurance? No Yes More than one Responsible Party E-mail Address _____

How did you first hear about our office? _____

Whom may we thank for referring you to our office? _____

What is your main reason for seeing an orthodontist? (check all that apply)

- Crooked teeth Crowding Close spaces Crossbite Overbite Bad bite Hard to chew Can't close mouth
 Jaw pain Headaches Don't like smile Cosmetics Other _____

Is the child concerned about their teeth? No Yes Is the child frightened or anxious about treatment? No Yes

—Continued on back—

DENTAL INFORMATION

Has child had previous treatment for TMJ Gum disease
By Whom? _____
Any previous orthodontic treatment? No Yes
When? _____
Is this a second opinion? No Yes
Why? _____
Who was the first? _____
Have other members of the family had orthodontic treatment?
If so, whom? _____
Are they satisfied with the end results? No Yes

Does the patient have any speech problems? No Yes
Please explain _____
Any injuries to face, head, mouth or teeth? No Yes
When? _____
Pain in or near ears? No Yes
When? _____
Clicking or locking of jaws? No Yes
When? _____
Headaches, facial pain or jaw joint problems? No Yes
If so, please explain _____

General Dentist – Dr. _____ Date of last visit _____

Does patient have any missing or extra teeth? _____

Any other information that would be helpful? _____

About your child's home care:

Please rate your child's oral hygiene. Good Fair Poor
Does the child brush their teeth daily? No Yes
Does the child floss their teeth? No Yes

Does child have any history of these habits?

Mouth Breathing Grinding of teeth
 Thumb sucking Leaning on chin or face
 Nail/Lip biting Other _____

MEDICAL INFORMATION

Overall medical health Good Fair Poor
Any history of the following: None
 Asthma Blood disease Diabetes
 Hepatitis AIDS/HIV Rheumatic Fever
 Anemia Heart disease Allergies
 Glaucoma Epilepsy Bone Disorders
Any other medical problems we should be aware of?

If female, has menstrual cycle started? No Yes
If so, approximately when? _____

Is there a tendency to Ear infections Colds Sore throats
Have tonsils and adenoids been removed? No Yes
If so, when? _____
List any drugs or medications being taken

List any allergies or drug sensitivities

Is premedication needed before dental treatment? No Yes

Physician – Dr. _____ Date of last visit _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary orthodontic services my child may need.
I further authorize that photos taken during treatment may be used in journal articles or promotional materials and are the property of Dr. Ginzler and Dr. Shaw.
I understand that where appropriate, credit bureau reports may be obtained.
Signature of parent or guardian: _____ Date: _____