



ORTHODONTIC ACQUAINTANCE CARD

PATIENT'S NAME _____ BIRTHDATE _____ AGE _____ SEX _____
Last First Middle

RES. ADDRESS _____ CITY _____ ZIP _____ TELEPHONE _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ LAST DENTAL CLEANING _____ PHYSICIAN _____

FATHER'S NAME _____ OCCUPATION _____
 EMPLOYED BY _____ BUS. TELEPHONE _____

MOTHER'S NAME _____ OCCUPATION _____
 EMPLOYED BY _____ BUS. TELEPHONE _____

HOBBIES AND SPORTS _____ GOES BY _____

RESPONSIBLE FINANCIAL PARTY _____ PARENTS ARE: MARRIED SINGLE DIVORCED

RESPONSIBLE PARTIES DRIVERS LICENSE# _____ RESPONSIBLE PARTY E-MAIL ADDRESS _____

FATHER'S SS# _____ CHILD LIVES WITH _____

MOTHER'S SS# _____ DENTAL INSURANCE _____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? _____ YES NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ YES NO

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? _____ YES NO

PLEASE LIST _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

DIABETES..... <input type="checkbox"/>	TUBERCULOSIS..... <input type="checkbox"/>	ENDOCRINE PROBLEMS..... <input type="checkbox"/>
FEVER BLISTERS..... <input type="checkbox"/>	CONTACT LENSES..... <input type="checkbox"/>	PROLONGED BLEEDING..... <input type="checkbox"/>
HEART TROUBLE..... <input type="checkbox"/>	EPILEPSY..... <input type="checkbox"/>	FAINTING OR DIZZINESS..... <input type="checkbox"/>
RHEUMATIC FEVER..... <input type="checkbox"/>	ASTHMA..... <input type="checkbox"/>	NERVOUS DISORDERS..... <input type="checkbox"/>
BONE DISORDERS..... <input type="checkbox"/>	KIDNEY INVOLVEMENT..... <input type="checkbox"/>	LIVER INVOLVEMENT..... <input type="checkbox"/>
HEPATITIS..... <input type="checkbox"/>	GLAUCOMA..... <input type="checkbox"/>	CEREBRAL PALSY..... <input type="checkbox"/>

GROWTH RATE SLOW..... AVERAGE..... FAST.....

RESEMBLES MOTHER..... FATHER..... ADOPTED.....

DISPOSITION OBEDIENT..... COOPERATIVE..... INDEPENDENT..... REBELLIOUS.....

DOES PATIENT HAVE TENDENCY TO COLDS..... SORE THROATS..... EAR INFECTIONS.....

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES NO WHAT AGE? _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAS THE PATIENT REACHED PUBERTY? GIRLS-HAS SHE STARTED MENSTRUATING? _____ YES NO

BOYS-HAS HIS VOICE CHANGED? _____ YES NO

DENTAL HISTORY

HAS PATIENT HAD PRIOR ORTHODONTIC TREATMENT? _____ YES NO

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ YES NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ YES NO

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE YES NO WHILE ASLEEP YES NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES NO

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

REASON FOR CONSULTATION _____

DATE _____ FORM COMPLETED BY _____ PARENTS SIGNATURE _____

SIBLINGS INFORMATION

As you know it is very important to begin orthodontic treatment at the correct time. It would be very helpful to have some additional information about the members of your immediate family. This would give us a good idea as to when they might benefit from a FREE orthodontic evaluation.

Thank You.

Dr. Copenhaver, Dr. Lugo & Dr. Schechter

Patient Name _____

Please list brothers and sisters from youngest to the oldest.

First Name	Last Name	Birth Date	School Grade	Sex
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____
_____	_____	____ / ____ / ____	_____	_____

Thanks again.