ORTHODONTIC ACQUAINTANCE FORM

Patient's Name Dr. Mrs. Ms. Mr. _____ Sex F M Date _____

Last Initial First Date of Birth Age

Medical History

Is patient in good health? _____ __yes __no

Has the patient reached puberty? Girls: Has she started Menstruation __yes __no

Boys: Has his voiced changed __yes __no

Is patient presently pregnant? _____ __yes __no

Does patient have any history of **MAJOR** illness? _____ __yes __no

Has the patient been under a physician's care within the past year? _____ __yes __no

If yes, please explain _____

List any drugs or medications now being taken, give reasons _____

Is patient allergic to Penicillin, or any other drugs? _____ __yes __no

Have Tonsils and adenoids been removed? __yes __no What age? _____

Does patient have tendency to __colds __sore throats __ ear infections

Has patient had any emotional problems or psychiatric care? _____

Check Any of the following that the patient has or had;

__Joint replacement
__Heart Valve replacement
__Rheumatic Fever
__Scarlet Fever
__Heart Disease
__Heart Murmur
__Diabetes
__High Blood Pressure
__Anemia
__Steroid Medications
__Liver Disease
__Tuberculosis
__Kidney Disease
__Prolonged Bleeding
__Epilepsy
__Bone Disorders
__Endocrine Problems
__Glaucoma
__Pneumonia
__Emphysema
__Asthma
__Fainting or Dizziness
__Nervous Disorders
__Other

Dental History

__Severe head or face injury
__Serious injury to teeth
__Jaw joint soreness
__Jaw joint clicking
__Jaw joint popping
__Ringing in ears
__Headaches (more than normal)
__Muscular soreness around Head and Neck
__Clenching/Grinding teeth
__Sensitive teeth
__Blisters on lip/mouth
__Thumb/finger sucking
__Mouth Breather
__Missing/extra teeth
__Plays wind instrument

Reason for this consultation _____

Is there any other information that may be helpful? _____

_____

Doctor's Comments: _____

_____

_____

_____

This information is complete and accurate to the best of my knowledge.

_____

Patient or Guardian's Signature

Medical Updates: _____ _____ _____ _____ _____ _____

Initial Date Initial Date Initial Date

ORTHODONTIC ACQUAINTAINCE FORM CONTINUED

Patient Name _____ Phone ( )_____

Res. Address _____

Street City Zip

Referred By _____

Patient'sDentist _____ Physician _____

If minor, Parent's or Guardian's Name _____ Daytime Phone( ) _____

_____ Daytime Phone( ) _____

If minor, names and ages of other children in family_____

_____

Has any family member or relative had Orthodontic treatment by Dr. Tingling? ___yes ___nc

If yes, who _____

Emergency Contact Information

Name_____

Relationship to patient _____

Phone # _____(home) _____ (work)

Responsible Party Information

1 Subscriber's Name: _____

Relationship to Patient: _____

Address_____

if different from the above patient

Home Phone #_____ Work Phone # _____

Name of Dental Insurance Co._____

Dental Insurance Co. Phone # _____

Place of employment_____

Social Security #_____

Group #_____

Date of Birth_____

2 Subscriber's Name: _____

Relationship to Patient: _____

Address_____

if different from the above patient

Home Phone #_____ Work Phone # _____

Name of Dental Insurance Co._____

Dental Insurance Co. Phone # _____

Place of employment_____

Social Security #_____

Group #_____

Date of Birth_____

Thank You!

_____

Patient or Guardian's Signature