ORTHODONTICS

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ACQUAINTANCE AND HEALTH QUESTIONNAIRE

FOR CHILD/ADOLESCENT PATIENT

Patient's Full Name _____ Age _____ Today's Date _____
Nickname _____ Birthdate _____ Sex _____
Home Address _____ Phone _____

School _____ Grade _____ Hobbies _____
Patient's Physician _____ Phone _____ City _____
Patient's Dentist _____ Phone _____ City _____
Date of last dental appointment _____ Reason _____
What orthodontic problem do you wish to have corrected? _____
What is the patient's attitude toward orthodontic treatment? _____
Additional information which you feel would make your child's association with us more enjoyable _____
_____

Father's Name _____ SS# _____
Address _____ Phone _____

Occupation _____ Employer _____ Phone _____
Mother's Name _____ SS# _____
Address _____ Phone _____
Family email address _____ Cell # _____
Occupation _____ Employer _____ Phone _____
Parents' marital status: Married _____ Single _____ Divorced _____ Separated _____ Widowed _____
Person responsible for payment _____ Relationship to Patient _____
Address _____ Phone _____

Do you have insurance that covers orthodontic treatment? _____
Have you seen another orthodontist? Yes No If yes, who? _____
Name of any family members we have seen _____
Names and ages of siblings _____
Whom may we thank for referring you to our office? _____

MEDICAL HISTORY (Please check if the patient has ever had any of the following conditions–give details below)

Yes	No		Yes	No		Yes	No		Yes	No	
___	___	Hepatitis	___	___	Cancer	___	___	Asthma			
___	___	Tuberculosis	___	___	Diabetes	___	___	Sinus Problems	___	___	Drug Allergies
___	___	Rheumatic Fever	___	___	Kidney Problems	___	___	Mental Retardation	___	___	Wear contact lenses
___	___	AIDS/HIV	___	___	Liver Problems	___	___	Emotional Problems	___	___	Currently Pregnant
___	___	Heart Disease	___	___	Bleeding Problems	___	___	Attention Deficit	___	___	Other (describe below)
___	___	Heart Murmur	___	___	Is antibiotic pre-medication required prior to dental visits?				___	___	Epilepsy / convulsions
___	___	**LATEX ALLERGY**									

Is the patient in good health? Yes ____ No ____ If no, explain _____
Is there any history of serious illness, accident, or operation? Yes ____ No ____ If yes, explain _____
Is the patient currently under the care of a physician for any problem at this time? Yes ____ No ____ If yes, explain _____
List any medication the patient is taking: _____ reason _____

DENTAL HISTORY (please check any that apply–give details below)

___ Grinding or clenching of teeth
___ Thumb sucking (age stopped____)
___ Facial or jaw joint pain
___ Injury to mouth or teeth
___ Missing or extra teeth
___ Difficulty chewing
___ Speech problems
___ None of the above
___ Previous periodontal treatment
Date/Location: _____
___ Previous orthodontic treatment
Date/Location: _____

Additional Information: _____
Doctor's notes: _____

GROWTH AND DEVELOPMENT HISTORY

Has the patient experienced recent rapid growth? If yes, when? _____ How much? _____
Females: Has menstruation begun? (when? month / year) _____

Your signature below confirms that the above information is correct.

Guardian's signature: _____