CHILD AQUAINTANCE FORM

TODAY'S DATE:______________________________

SEX: M OR F

PATIENT NAME:____DATE OF BIRTH:___________________
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS:____CITY:__________________________ZIP CODE:__________

HOME PHONE: __________________________ CELL PHONE:_____________________________

MOTHER'S NAME:______________________________________Place of employment_________________________

ADDRESS:____CITY:__________________________ZIP CODE:__________

HOME PHONE: _________________ CELL PHONE:______________________WORK PHONE:________________

FATHER'S NAME:____________________________________Place of employment____________________________

ADDRESS:____CITY:__________________________ZIP CODE:__________

HOME PHONE: _________________ CELL PHONE:______________________WORK PHONE:________________

WHO MAY WE CONTACT IN CASE OF EMERGENCY?____________________________PHONE____________________

WHO MAY WE THANK FOR REFERRING YOU? ____

WHO IS YOUR GENERAL DENTIST? NAME:________________________________PHONE#:__________________________

WHO IS YOUR PHYSICIAN? NAME:_______________________________________PHONE#:__________________________

WHAT ARE THE NAMES AND AGES OF PATIENT'S SIBLINGS?____

____

MEDICAL/DENTAL HEALTH INFORMATION

PLEASE CIRCLE YES OR NO

DOES THE PATIENT HAVE A HISTORY OF MAJOR ILLNESS? YES NO
IF YES, PLEASE EXPLAIN:____

IS THE PATIENT CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO
IF YES, PLEASE EXPLAIN:____

IS THE PATIENT CURRENTLY UNDER PSYCHIATRIC/EMOTIONAL CARE? YES NO
IF YES, PLEASE EXPLAIN:____

HAS THE PATIENT HAD THEIR TONSILS AND/OR ADENOIDS REMOVED? YES NO
IF YES, AT WHAT AGE?___________

HAS THE PATIENT REACHED PUBERTY? YES NO GIRLS: HAS SHE STARTED MESTRUATION? YES NO
BOYS: HAS HIS VOICE CHANGED? YES NO

IS THE PATIENT CURRENTLY TAKING ANY DRUGS OR MEDICATIONS? YES NO
IF YES, PLEASE LIST MEDICATION AND DOSAGE:____

PLEASE COMPLETE OTHER SIDE

DOES PATIENT HAVE ANY ALLERGIES? YES NO
IF YES, PLEASE LIST:____

____

PLEASE CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN OR IS CURRENTLY BEING TREATED:

- ☐ DIABETES
- ☐ RHEUMATIC FEVER
- ☐ ANEMIA
- ☐ KIDNEY DISORDERS
- ☐ GLAUCOMA
- ☐ NERVOUS DISORDERS
- ☐ PNEUMONIA
- ☐ BONE DISORDERS
- ☐ ASTHEMA
- ☐ EPILEPSY
- ☐ ENDOCRINE PROBLEMS
- ☐ LIVER INVOLVEMENT
- ☐ COMPROMISED IMMUNE SYSTEM
- ☐ HEART TROUBLE
- ☐ TUBERCULOSIS
- ☐ PROLONGED BLEEDING
- ☐ FAINTING OR DIZZINESS

PLEASE CHECK ANY OF THE FOLLOWING THAT THE PATIENT HAS FREQUENTLY:

- ☐ COLDS
- ☐ SORE THROATS
- ☐ EAR INFECTIONS
- ☐ RESPIRATORY INFECTIONS
- ☐ CLENCHING/GRINDING OF THE TEETH IF YES, WHEN ____________________
- ☐ JAW PAIN
- ☐ BLISTERS ON MOUTH OR LIPS IF YES, WHERE______________________________
- ☐ CLICKING OR POPPING OF JAW IF YES, WHICH SIDE LEFT RIGHT (CIRCLE)

HAS PATIENT EVER SUCKED HIS/HER THUMB OR FINGERS? YES NO
IF YES, TO WHAT AGE? ____________________

DOES PATIENT HAVE ANY SPEECH PROBLEMS? YES NO
IF YES, PLEASE EXPLAIN____

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

HAS PATIENT HAD ANY TEETH REMOVED? YES NO
IF YES: WHICH ONES____________________________AT WHAT AGE_________________________

HAS PATIENT EVER HAD ANY INJURIES TO FACE, MOUTH, OR TEETH? YES NO
IF YES, WHEN AND WHERE____

HAS PATIENT EVER BEEN INFORMED OF MISSING OR EXTRA TEETH?
IF YES, PLEASE EXPLAIN____

HAS PATIENT PREVIOUSLY BEEN EVALUATED BY ANOTHER ORTHODONTIST? YES NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? YES NO

WHAT ARE YOUR PRIMARY CONCERNS?____

____

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

____

(SIGNATURE OF PARENT OR GUARDIAN DATE