ORTHODONTIC ACQUAINTANCE FORM

Date ___________________

Demographic Information

Patient's Name ____ Name they would like to be called _____________________

Age ______ Birth date ________________ Social Security Number ___________________________ Sex (Circle one) F M

Address ____
Street City State Zip Code

Home Phone Number ____________________ Names & ages of siblings ____

Mother's Name ____ Social Security # _______________________________

Mother's Employer ____________________________ Work Phone # ________________ Mobile Phone # ________________

Father's Name____ Social Security #__________________________________

Father's Employer ____________________________ Work Phone # ________________ Mobile Phone # ________________

Who has legal custody of patient? ________________________ Patient lives with: Mother Father Both Other ___________

Child's Physician ___________________________________ Phone # _______________ Date of last exam _______________

Whom may we thank for referring you to us? ____

What is the reason for today's visit? ____

Please provide your email address if you would like to receive your appointment confirmations by email:

Email Address: ____ (Mother / Father / Other____________)

YES NO

Health History

___ ___ Has your child ever had a health problem? Please explain____

___ ___ Has your child ever been hospitalized? Please give reason and dates_________________________________

___ ___ Is your child allergic to anything?____

___ ___ Is your child currently taking any medications? Please give medication and reason _____________________

___ ___ Were there any problems at birth?____

Please check if your child has been treated for any of the following:

___ Heart disease ___ Liver disease ___ Kidney disease ___ Bleeding/transfusion

___ Asthma ___ Anemia ___ Rheumatic fever ___ Seizures

___ Diabetes ___ Hepatitis ___ Cerebral palsy ___ Cleft lip/palate

___ AIDS ___ Depression ___ ADHD/ADD ___ Learning Disability

___ Speech/hearing ___ Other Problems (Please explain) ____

Reason for orthodontic consultation? ____

YES NO

Dental History

___ ___ Has an orthodontist been consulted previously? Name ____

___ ___ Have you been informed of any missing or extra permanent teeth? ______________________________

___ ___ Have there been injuries to the face, mouth, or teeth? _______________________________________

___ ___ Does your child have pain with chewing, yawning or wide opening? ______________________________

___ ___ Does your child's jaw make noise and is pain associated with the sounds? _______________________

___ ___ Has either parent had orthodontic treatment? ____

Date of last dental examination ________________Dentist's Name & phone number ________________________________

YES NO

Growth Data

___ ___ Do your feel your child is still actively growing?

___ ___ Females: Has menstruation started? What age: ____________________________________

___ ___ Males: Has there been a voice change or change in facial hair?

(Office Use Only)

Clinical Findings

Patient's height ____________________ Patient's weight ____________________

EXTRAORAL

Profile: ______________ A-P ______________ Lips A-P ______________ Asymmetry

______________ Vertical ______________ Lip Competency

TMJ ______________ WNL ______________ Pain ______________Clicking

______________ Crepitus ______________ Deviation ______________ LOM

INTRAORAL

Soft tissues: _______________ Normal ______________ Oral hygiene ______________ Asymmetry

Comments: ____

Mandible: ______________ ALD ______________ Missing teeth ______________ COS

Comments: ____

Maxilla: ______________ ALD ______________ Missing teeth

Comments: ____

A-P: ______________ Molar L ______________ Canine L

______________ Molar R ______________ Canine R ______________ Overjet

Vertical: ______________ Overbite

Transverse: ______________ Midlines ______________ Crossbites

Recommendations:____

____

____

UPDATE Date: _______________

A-P: _______________ Molar L ______________ Canine L

_______________ Molar R ______________ Canine R _______________ Overjet

Vertical: _______________ Overbite

Transverse: _______________ Midlines ______________ Crossbites

Recommendations:____

____

____

UPDATE Date: _______________

A-P: _______________ Molar L ______________ Canine L

_______________ Molar R ______________ Canine R _______________ Overjet

Vertical: _______________ Overbite

Transverse: _______________ Midlines ______________ Crossbites

Recommendations:____

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