Kelly Family ORTHODONTICS

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CHILD ACQUAINTANCE FORM

Date: _____

Patient's Name_____ Nickname_____ Age _____
Date of Birth _____ Sex_____ Phone Number_____ [ ] Cell [ ] Home
Home Address_____ City _____ State_____ Zip _____
Patient's Dentist _____ Patient's Physician _____
Whom may we thank for referring you? _____

Mother's Name _____ Date of Birth_____
Address (if different) _____
Social Security # _____ Phone # _____
Employer/Occupation/ Business address _____

Married [ ] Single [ ] Divorced [ ] Widowed [ ]

Father's Name _____ Date of Birth _____
Address (if different) _____
Social Security # _____ Phone # _____
Employer/Occupation/ Business address _____

Other Responsible Party _____Relationship: _____ Date of Birth_____
Address (if different) _____
Social Security # _____ Phone # _____
Employer/Occupation/ Business address _____

Names & ages of other children in the family _____
Emergency Contact (name & phone number) _____

DENTAL HISTORY

1. When was the patient's last dental exam? _____
2. Has the patient ever had orthodontic treatment? Yes [ ] No [ ]
3. Does the patient have/had periodontal or gum disease? Yes [ ] No [ ]
4. Have you ever been informed of any missing or extra permanent teeth? Yes [ ] No [ ]
5. Has the patient ever been teased about the appearance of his/her teeth? Yes [ ] No [ ]
6. Have you noticed lumps, sores or irritated areas in the patient's mouth? Yes [ ] No [ ]
7. Has the patient ever been treated for problems of his/her jaw joints? Yes [ ] No [ ]
8. Does the patient have a history of thumb sucking? Yes [ ] No [ ]
9. Does the patient have a history of mouth breathing? Yes [ ] No [ ]
10. Does the patient take antibiotic premedication before any dental procedures? Yes [ ] No [ ]

What do you wish to gain through orthodontic treatment? _____
Is there any additional information we should know? _____

MEDICAL HEALTH HISTORY

1. Please describe the patient's present health Excellent [ ] Good [ ] Fair [ ] Poor [ ]
2. Has the patient's health changed in the last year? Yes [ ] No [ ]
3. Has the patient ever been hospitalized for illness or surgery? Yes [ ] No [ ]
4. Has a doctor treated the patient for any condition in the last two years? Yes [ ] No [ ]
   Please describe: _____
5. Is the patient ALLERGIC to any drugs or other substances? Yes [ ] No [ ]
   Please list: _____
6. Has anyone in your family ever had diabetes? Yes [ ] No [ ]
7. Is the patient's diet restricted or specially prescribed? Yes [ ] No [ ]
8. Has the patient ever taken bisphosphonates for bone disorders or cancer? Yes [ ] No [ ]
9. Is the patient taking any medications (aspirin, vitamins, hormones, etc)? Yes [ ] No [ ]
   If so, please list them with dosages: _____
   _____

PLEASE INDICATE YES OR NO FOR EVERY CONDITION, EVEN IF YOU NO LONGER HAVE IT

AIDS/HIV	Yes [ ] No [ ]	Eye Problems	Yes [ ] No [ ]	Nasal Obstructions	Yes [ ] No [ ]
Anemia	Yes [ ] No [ ]	Fainting/Dizziness	Yes [ ] No [ ]	Osteoporosis/Osteopenia	Yes [ ] No [ ]
Anxiety/Depression	Yes [ ] No [ ]	Fever Blisters/Cold Sores	Yes [ ] No [ ]	Psychiatric Care	Yes [ ] No [ ]
Artificial Joints/Valves	Yes [ ] No [ ]	Glaucoma	Yes [ ] No [ ]	Rheumatic Fever	Yes [ ] No [ ]
Arthritis	Yes [ ] No [ ]	Hay fever/Allergies	Yes [ ] No [ ]	Scarlet Fever	Yes [ ] No [ ]
Asthma	Yes [ ] No [ ]	Hardenings of Arteries	Yes [ ] No [ ]	Shortness of Breath	Yes [ ] No [ ]
Autism/Asperger's	Yes [ ] No [ ]	Hearing Problems	Yes [ ] No [ ]	Sinus Problems	Yes [ ] No [ ]
Bone Fractures	Yes [ ] No [ ]	Heart Murmurs/Defects	Yes [ ] No [ ]	Speech Disorder/Problems	Yes [ ] No [ ]
Cancer	Yes [ ] No [ ]	Heart Problems	Yes [ ] No [ ]	Stroke	Yes [ ] No [ ]
Chest Pains	Yes [ ] No [ ]	Hepatitis	Yes [ ] No [ ]	Swollen Glands	Yes [ ] No [ ]
Congenital Heart Lesions	Yes [ ] No [ ]	High/Low Blood Pressure	Yes [ ] No [ ]	Thyroid Problems	Yes [ ] No [ ]
Congenital Heart Defects	Yes [ ] No [ ]	Hives/Rash	Yes [ ] No [ ]	Tuberculosis	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Immune System Problems	Yes [ ] No [ ]	Tumors/Growths	Yes [ ] No [ ]
Eating Disorders	Yes [ ] No [ ]	Infections	Yes [ ] No [ ]	Ulcers	Yes [ ] No [ ]
Emotional Problems	Yes [ ] No [ ]	Jaundice	Yes [ ] No [ ]		
Emphysema	Yes [ ] No [ ]	Kidney Problems	Yes [ ] No [ ]	Other:	
Endocrine Problems	Yes [ ] No [ ]	Liver Problems	Yes [ ] No [ ]		
Epilepsy	Yes [ ] No [ ]	Lung Disease/Problems	Yes [ ] No [ ]		
Excessive Bleeding	Yes [ ] No [ ]	Mumps	Yes [ ] No [ ]		

Please advise us if there are ever any changes, thank you!

Print Guardian's Name _____ Guardian's Signature _____

Reviewed by _____