ADAMS ORTHODONTICS

Child/Adolescent
Orthodontic Acquaintance Form

Patient's name _____ Nick name_____

Date of birth _____ Age ____ years ____ months ____ Sex___ M___ F

Address: Street _____

City _____ State _____ Zip _____

Telephone: (____) _____ Daytime (____)_____ School & Grade _____

Person responsible for financial matters:

Name _____

Address: Street _____

City _____ State _____ Zip _____

Telephone: (_____) _____ Business: (_____) _____

Does patient have insurance for orthodontic treatment? _____ Yes _____ No

If yes, Primary subscriber name/Company_____ SS#/ID# _____

Secondary subscriber name/Company_____ SS#/ID# _____

I. FAMILY STATUS:

Father's name _____ D.O.B. _____

Employed by/Occupation _____Business phone (____)_____

Mother's name _____ D.O.B. _____

Employed by/Occupation _____ Business phone (____)_____

Names and Ages of Siblings _____

Marital status of parents _____ Is the patient adopted? ___ Yes ___ No

II. MEDICAL HISTORY:

Family physician _____ Phone (____) _____

Has Patient ever had:

__ HIV	__ TB	__ Kidney disease	__ Cold sores
__ Anemia	__ Diabetes	__ Heart condition	__ Oral ulcers
__ Bleeding	__ Epilepsy	__ Cerebral palsy	__ Injury to face/head
__ Asthma	__ Hepatitis	__ Rheumatic fever	__ Sore or clicking jaw joint
__ Arthritis	__ Lung disease	__ Hearing problems	__ Latex allergy

Other illness or operations: _____

Is the patient receiving any medication? ___ Yes ___ No List _____

List any allergies or drug sensitivity _____

Does the patient need to be premedicated (antibiotics) for routine dental procedures?

Specify and describe _____

Have the patient's tonsils and/or adenoids been removed? _____ Age _____

Describe any birth defects: _____

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III. DENTAL HISTORY:

Family Dentist _____ Date of last examination _____

Injury or Trauma to the teeth or gums? __ Yes __ No Describe _____

How often does the patient brush his/her teeth?_____

Has the patient ever had:

Unfavorable dental experiences? ___ Yes ___ No Specify _____

Speech Therapy? ___ Yes ___ No

Previous orthodontic consultation and/or treatment? ___ Yes ___ No by whom _____

Has any member of the family had orthodontic treatment? ___ Yes ___ No

If yes, describe _____

Does the patient:

Grind his/her teeth? ___ Yes ___ No Bite his/her fingernails? ___ Yes ___ No

Suck thumb, finger, etc.? ___ Yes ___ No Previously until _____ years old

Does the patient's home water supply have fluoride? ___ Yes ___ No

Describe the main reason why your child is seeking orthodontic treatment

_____

IV. BEHAVIOR:

Personality: __ Calm __ Outgoing __ Quiet __ Cooperative __ Uncooperative __ Slow

Progress at school: __ Behind children of same age __ Average __ Advanced

Best subject in school: _____

Hobbies and Interests: _____

V. PATIENT'S TREATMENT ATTITDUE:

Is the patient aware of an orthodontic problem? __ Yes __ No

The patient's interest in orthodontic treatment is:

__ Wants treatment __ Willing if treatment is necessary __ Unwilling

VI. GROWTH AND DEVELOPMENT STATUS:

Patient's height _____, weight _____ Mother's height _____ Father's height _____

Female patient's only:

a. Has the patient started her menstruation? ___ Yes ___ No At what age? ____

b. Is the patient pregnant? __ Yes __ No

Male patient's only:

a. Voice changes? __ Yes __ No

b. Facial hair growth? __ Yes __ No

Signature and relationship to patient: _____ Date _____

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