ORTHODONTIC ACQUAINTANCE CARD

Welcome to our office...
Please assist us by completing the following questions...

Date ______________________

Patient's name ______________________ Nickname ______________ Social security no. ______________
Res. address ______________________ City ______________ Zip ________ Phone ______________
Age ______ Sex ______ Date of birth ______________ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
Patient's dentist ______________________ Address ______________________
Physician ______________________ Who may we thank for referring you? ______________________
Names of other members of your family treated by our office ______________________
Person responsible for account ______________________
Address ______________________ City ______________ Zip ________
Do you have an insurance plan which covers orthodontic treatment? ☐ Yes ☐ No Name of company ______________
Employed by ______________________ Occupation ______________ Bus. telephone ______________
Business address ______________________
Spouse's name ______________________ Occupation ______________ Social security no. ______________
Employed by ______________ Business address ______________________ Bus. telephone ______________
List sports and interests ______________________

MEDICAL HISTORY

	YES	NO	?
Is patient in good health? ______	☐	☐	☐
Does patient have any history of major illness? ______	☐	☐	☐

Check any of the following for which the patient has been treated:

DIABETES ☐	ANEMIA ☐	PROLONGED BLEEDING ☐	HEPATITIS ☐
PNEUMONIA ☐	EPILEPSY ☐	FAINTING/DIZZINESS ☐	HIGH BLOOD PRESSURE ☐
HEART TROUBLE ☐	ASTHMA ☐	NERVOUS DISORDERS ☐	HIV ☐
RHEUMATIC FEVER ☐	KIDNEY INVOLVEMENT ☐	LIVER INVOLVEMENT ☐	ARTHRITIS ☐
BONE DISORDERS ☐	TUBERCULOSIS ☐	ENDOCRINE PROBLEMS ☐	OTHER NOT LISTED ______

	YES	NO	?
Does patient have tendency to: ☐ colds ☐ sore throat ☐ ear infections? ______	☐	☐	☐
Have tonsils and adenoids been removed? What age? ______	☐	☐	☐
Any other operations? ______	☐	☐	☐
List any drugs or medications now being taken (give reasons) ______			
List any allergies or drug sensitivity ______			
Do you wear contact lenses? ______	☐	☐	☐
Have wisdom teeth been removed? What age? ______	☐	☐	☐
Have you seen a physician in last 2 years? Date of last physical exam ______	☐	☐	☐
If yes, why? ______			

DENTAL HISTORY

	YES	NO	?
Does patient vomit, gag or faint easily? ______	☐	☐	☐
Have there been any injuries to the face, mouth or teeth? ______	☐	☐	☐
Do you have any problems with your speech? ______	☐	☐	☐
Are you a mouth breather? ☐ while awake ☐ while asleep ______	☐	☐	☐
Do you have frequent headaches? ______	☐	☐	☐
Have you had any clicking or discomfort in jaw joints near ears? ______	☐	☐	☐
Have you been informed of any missing or extra permanent teeth? ______	☐	☐	☐
Have you had any previous orthodontic examinations? ______	☐	☐	☐
Do you clench or grind your teeth? ______	☐	☐	☐
Have you had any periodontal treatment? ______	☐	☐	☐
When did you last visit your dentist? ______ Were any x-rays taken?	☐	☐	☐
How many times a day do you brush your teeth? ______			
Reason for orthodontic examinations: ______			

Patient's name ______ LAST ______ FIRST

____
SIGNATURE

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Member
American Association of
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