Acquaintance Form

DATE_____

PT-ID_____

AGE _____

(For Office Use Only)

Patient's Name_____ M / F Nickname_____
First Middle Last

PATIENT INFORMATION

Patient Address_____

City_____ State_____ Zip_____

Date of Birth_____ Age_____ Primary Email Address _____

Home Phone_____ Person to contact for appointments_____ Relationship_____

Emergency Contact (person not living with you) _____ Phone _____ Relationship_____

Contact's Address_____ City_____ State_____ Zip_____

Patient's Dentist_____ Physician_____ Oral Surgeon_____

Whom may we thank for referring you? ☐ Dentist ☐ Family Member ☐ Friend Name_____

ACCOUNT INFORMATION

Person(s) responsible for this account _____

Parents are ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

RESPONSIBLE PARTY

FATHER'S NAME _____ SS#_____ Date of Birth_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ OK to call at work?____

Employer_____ Occupation_____

MOTHER'S NAME _____ SS#_____ Date of Birth_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____ OK to call at work?____

Employer_____ Occupation_____

Names of Brothers & Sisters _____ Birth Dates (MM/DD/YYYY) _____

_____ _____

_____ _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance_____

Insured's Name_____ Birth Date_____

ID Number_____

Group Number_____

Toll Free Number_____

Secondary Dental Insurance_____

Insured's Name_____ Birth Date_____

ID Number_____

Group Number_____

Toll Free Number_____

I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure payment of benefits I understand that I am financially responsible for all charges whether or not deemed payable by insurance. I authorize the use of this signature on all insurance submissions.

Insured's Signature ➢

MEDICAL HISTORY

yes no dk/u Birth defects or hereditary problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
yes no dk/u Mental health or behavioral problem?
yes no dk/u Autism Diagnosis, ADD, ADHD, or Asperger's Syndrome?
yes no dk/u AIDS or HIV positive?
yes no dk/u Diabetes?
yes no dk/u Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?
yes no dk/u Cardiovascular problem, heart trouble, heart attack, angina, coronary insufficiency, atherosclerosis, stroke, inborn heart defects, high blood pressure, or rheumatic heart disease?
yes no dk/u Frequent headaches, colds or sore throats?
yes no dk/u Hay fever, asthma, sinus trouble, or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Allergies or drug reactions? Describe:

_____

yes no dk/u Are you taking medication, nutrient supplements or non-prescription medicine? Please name them:

_____

yes no dk/u Operations? Describe:

_____

yes no dk/u Hospitalized for:

_____

yes no dk/u Other physical problems or symptoms? Describe:

_____

yes no dk/u Date of menarche (female, mo. /yr.)

_____

yes no dk/u Onset of puberty (approximate mo. /yr.)

_____

yes no dk/u Being treated by another health care professional? For:

_____

DENTAL HISTORY

yes no dk/u Started teething very early or late?
yes no dk/u Primary (baby) teeth removed that were not loose?
yes no dk/u Congenitally missing teeth?
yes no dk/u Supernumerary (extra) teeth?
Teeth removed?_____
yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u "Dead teeth," root canals treated?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal "gum problems"?
yes no dk/u Thumb or finger, sucking habit? Until age:

_____

yes no dk/u Abnormal swallowing habit (tongue thrust)?
yes no dk/u History of speech problems?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Difficulty encountered in chewing or jaw opening?
yes no dk/u Concerned about spaced, crooked, or protruding teeth?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Has patient ever had a prior orthodontic examination or treatment? With whom:_____
yes no dk/u Would patient object to wearing orthodontic appliances braces should they be indicated?

Reason For Exam? _____

Successful treatment greatly depends upon the patient's complete cooperation in following instructions and maintaining oral hygiene.
Are there any restrictions, handicaps, or problems that may complicate treatment?_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/ dental status I will so inform this practice. I give my consent to any advisable and necessary dental procedures to be administered by the orthodontist or by supervised staff for diagnostic purposes or dental treatment. I understand I am financially responsible for all charges.

*If ANY PORTION of this fee is not paid by insurance for any reason, I understand it becomes my obligation. In addition, all collection costs and attorney fees incurred in the collection of overdue accounts will be borne by the responsible party.

Signature ➤ Date ➤