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SPECIALISTS IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALISTS IN PEDIATRIC DENTISTRY

Youth/Adolescent Orthodontic Acquaintance Form (Ages 1-7 yrs.)

Child's Name:____Sex:_______ Date of Birth:___/___/_____Age:______
Address:____City:_____________ State:_______ Zip:___________
School: ____Interests or Hobbies:_____________________________
Primary Phone Number ___________________Child Lives With: □ Both Parents □ Mother □ Father □ Guardian
Responsible Financial Party:_________________________Ages of Children at Home: _______________________
Do you have dental insurance?_______________________With whom? __________________________________

Father:____Father's Social Security:________________________
Employed by:____Occupation:_________________________________
Bus. Address:____Home Address:______________________________
Bus. Phone:____Cell Phone:__________________________________
Drivers license:______________________________________Date of Birth:________________________________

Mother:____Mother's Social Security:_______________________
Employed by:____Occupation:_________________________________
Bus. Address:____Home Address:______________________________
Bus. Phone:____Cell Phone:__________________________________
Drivers license:______________________________________Date of Birth:________________________________

Physician:____City:_____________ Phone:____________________
Dentist:____City:_____________ Phone:____________________

WHOM MAY WE THANK FOR REFERRING YOU TO US?____
____

MEDICAL HISTORY-check the answer to the right and provide the details on the line:
Is your child in good health? □Yes □No ____
Approximate date of last physician visit and why? □ Yes □ No _________________________________
Has your child ever had a serious illness? □ Yes □ No ____
Have adenoids or tonsils been removed? □ Yes □ No If yes, what age? ___________________________

Check any of the following conditions currently present or in past history:

□ AIDS OR HIV POSITIVE	□ ASTHMA	□ EPILEPSY
□ DIABETES	□ KIDNEY INVOLVEMENT	□ LIVER INVOLVEMENT
□ HEART TROUBLE	□ GLAUCOMA	□ ARTHRITIS OR JOINT DISEASE
□ RHEUMATIC FEVER	□ ENDOCRINE PROBLEMS	□ EMOTIONAL PROBLEMS
□ BONE DISORDERS	□ PROLONGED BLEEDING	□ NERVOUS DISORDER
□ HEPATITIS	□ TUBERCULOSIS	□ FAINTING OR DIZZINESS

Comments:____
____
____

Other illnesses we should know about:____
____

(Please turn page over)

Does your child have any physical or mental disabilities or handicaps? ☐Yes ☐No Explain:___________________________
____
____

Please list all prescription drugs or medications taken in the last 3 months (give reason):_____________________________
____
____

List all allergies or drug sensitivities:____
____

DENTAL HISTORY

When was your child's last dental visit (approximate date?) ___/___/_____
Was all recommended dental work completed?..☐ Yes ☐ No
Have there ever been any injuries to the face, mouth, or teeth?..☐ Yes ☐ No
Does your child brush his or her teeth 3 times a day?...☐ Yes ☐ No
Does he or she floss daily?...☐ Yes ☐ No
Does your child have any missing or extra permanent teeth? ....☐ Yes ☐ No
Has your child ever noticed pain, clicking sounds, or locking in the jaw joint?.......................................☐ Yes ☐ No

HABITS AND PERSONALITY

Does your child have any of these habits:
☐ Thumb or finger sucking ☐Mouth breathing ☐Tongue thrust (abnormal swallowing) ☐Clenching or grinding teeth
☐Other Oral habits____
Child's ability to follow through with responsibilities (homework, housework, etc.?) ☐Good ☐Average ☐Poor

Please check all the words which seem to best describe your child:

☐ Calm	☐ High-Strung	☐ Spoiled	☐ Active	☐ Cooperative
☐ Moody	☐ Curious	☐ Fearful	☐ Defiant	☐ Shy
☐ Talkative	☐ Compulsive	☐ Friendly	☐ Sympathetic	☐ Temper Tantrums
☐ Leader	☐ Quiet	☐ Task oriented	☐ People Oriented	☐ Helpful

What is your child's attitude towards orthodontic treatment: ☐Eager ☐Disinterested ☐Hostile

GROWTH AND DEVELOPMENT (The following questions pertain to orthodontic evaluation)

Is your child adopted?..☐ Yes ☐ No
Have you ever been told your child has a growth problem?..☐ Yes ☐ No
Child's Height: ft. in. Father's Height: ft. in. Mother's Height: ft. in.
Has your child reached puberty?
GIRLS..Has she started menstruating? ☐ Yes ☐ No
....If yes, what was the age of onset? ________
BOYS..Has his voice changed? ☐ Yes ☐ No
Has your child's shoe size recently changed?..☐ Yes ☐ No

ORTHODONTIC HISTORY (The following questions pertain to orthodontic evaluation)

Please describe your child's orthodontic problems as you see it:
Are you pleased with his or her facial profile?..☐ Yes ☐ No
Has an orthodontist been consulted previously? ....☐ Yes ☐ No
Has your child ever had past orthodontic treatment?____ If so, who treated your child?__________________________
Does anyone in the family have a similar dental or facial condition? ....☐ Yes ☐ No
What would you like orthodontic treatment to accomplish?____
____

CONSENT (please read and sign below)

Your child is a minor: it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including diagnostic radiographs. If my child ever has a change in his/her health or medications, I will inform the doctor at the next appointment without fail.
Date:____________________________Name: __________________________Signature:____

FINANCIAL TERMS I will be responsible for the cost of this dental care. I understand, by signing below that if I do not pay, I will be liable for attorney fees and court costs associated with collection of monies due and permission is hereby granted to obtain a credit report. On all past due accounts, a monthly 2.5 % interest charge will be assessed. Non sufficient fund checks are charged a $35.00 fee.
Date:____________________________Name: __________________________Signature:____