



**Youth/Adolescent Acquaintance Form (Ages 7-18 yrs.)**

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
School: \_\_\_\_\_ Interests or Hobbies: \_\_\_\_\_  
Primary Phone Number \_\_\_\_\_ Child Lives With \_\_\_\_\_  
Responsible Financial Party: \_\_\_\_\_ Ages of Children at Home: \_\_\_\_\_  
Do you have dental insurance? \_\_\_\_\_ With whom? \_\_\_\_\_

Guardian 1: \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Guardian's Social Security: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Bus. Address: \_\_\_\_\_ Home Address: \_\_\_\_\_  
Bus. Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Drivers license: \_\_\_\_\_ Email Address \_\_\_\_\_

Guardian 2: \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Guardian's Social Security: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Bus. Address: \_\_\_\_\_ Home Address: \_\_\_\_\_  
Bus. Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Drivers license: \_\_\_\_\_ Email Address \_\_\_\_\_

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:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> AIDS OR HIV POSITIVE | <input type="checkbox"/> ASTHMA             | <input type="checkbox"/> EPILEPSY                   |
| <input type="checkbox"/> DIABETES             | <input type="checkbox"/> KIDNEY INVOLVEMENT | <input type="checkbox"/> LIVER INVOLVEMENT          |
| <input type="checkbox"/> HEART TROUBLE        | <input type="checkbox"/> GLAUCOMA           | <input type="checkbox"/> ARTHRITIS OR JOINT DISEASE |
| <input type="checkbox"/> RHEUMATIC FEVER      | <input type="checkbox"/> ENDOCRINE PROBLEMS | <input type="checkbox"/> EMOTIONAL PROBLEMS         |
| <input type="checkbox"/> BONE DISORDERS       | <input type="checkbox"/> PROLONGED BLEEDING | <input type="checkbox"/> NERVOUS DISORDER           |
| <input type="checkbox"/> HEPATITIS            | <input type="checkbox"/> TUBERCULOSIS       | <input type="checkbox"/> FAINTING OR DIZZINESS      |
| <input type="checkbox"/> LATEX ALLERGIES      | <input type="checkbox"/> DENTAL PHOBIA      | <input type="checkbox"/> SENSITIVE GAG REFLEX       |

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

**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: \_\_\_\_\_