

Acquaintance Form

haymoreandward
orthodontics
ward orthodontics pa

Date

Patient name (First) (Middle) (Last) Name Called

Home Address City State Zip Home Phone

Sex M F Birth date Age General Dentist

Friends or Relatives treated here Referred By

Medical History

Please check box if patient has or has had

Please Check box if answer is yes:

- Joint Swelling, Bone Disorders, Heart Trouble, Rheumatic Fever, Thyroid Problems, Diabetes, Hepatitis, Emotional Problems, Brain Injury, Kidney or Liver Involvement, AIDS or AIDS Related Complex, Allergies (please list), Tuberculosis, Anemia, Asthma, Epilepsy, Prolonged Bleeding, Faintness/Dizziness, Tonsils Removed, Adenoids Removed, Sore Throats, Tonsillitis, Earaches

- Any injuries to face, mouth, teeth? (circle), Mouth-breathing when asleep, awake? (circle), More than average amount of tooth decay?, Any missing permanent teeth?, Any extra permanent teeth?, Visits dentist regularly?

Date of last dental visit Cleaning

Has consulted an orthodontist previously:

Reason:

List any other serious or medical problems not listed above

Describe

- Is this visit for a second opinion?, Family history of underbite (strong lower jaw), History of thumb/finger sucking habit?, Any history of speech therapy?, Any difficulty in swallowing or chewing?, Any pain or clicking when opening mouth?, Adopted

List drugs or medications now being taken:

Sports:

Is patient under physician's care presently?

What about your smile would you like to see different?

Reason:

Patient's attitude towards having orthodontics: (circle one)

Name of Physician:

Want it done Does Not Want Does not Care

Do you require antibiotic pre-medication prior to dental procedures?

Father's Name

Mr. Dr. Rev. Birth Date Marital Status

Address City State Zip Yrs. at this address

Cell Phone Email

Employer Yrs. with this employer Occupation Work phone

Dental Insurance Carrier Carriers Phone

Group # ID#

Mother's Name

Mrs. Ms. Rev. Birth Date Marital Status

Address City State Zip Yrs. at this address

Cell Phone Email

Employer Yrs. with this employer Occupation Work phone

Dental Insurance Carrier Carriers Phone

Group # ID#