Patient Acquaintance Card

Patient Information

Date _____ / _____ / _____

Name _____ Preferred Name _____ Age _____ Sex _____
Last First Initial Date of Birth _____ / _____ / _____

Home Address: _____
Street City State Zip

Phone: (H) (_____)_____ (C) (_____)_____ Email: _____

School _____ Grade _____ Favorite Hobby _____

Do you have orthodontic benefit? _____ If so, company name: _____

Who is financially responsible for this account? _____ SSN_____

Parents' Information

	Father	Mother
Name		
Home Address		
Phone (HM & Cell)		
Occupation & Employer		
Work Phone		
Work Address		

Medical History

Are you in good health? _____ Height _____ ft _____ in Weight _____ lb.

Do you have a history of major illness? _____ Physician _____

List current medications and reasons for taking them: _____

Allergies: List any known drug, latex or other allergies / sensitivities: _____

Do you smoke or use tobacco? _____ Drink coffee / tea? _____

Have you reached puberty? _____ Female: Started Menstruation? _____ If yes, when? _____

Male: Voice Changed? _____ If yes, when? _____

Check any of the following for which you have been treated:

_____ Diabetes	_____ Anemia	_____ Bleeding Disorder	_____ Heart Disease
_____ Pneumonia	_____ Tuberculosis	_____ Rheumatic Fever	_____ Kidney Disease
_____ Epilepsy / Seizures	_____ Fainting / Dizziness	_____ Nervous Disorders	_____ ADHD
_____ Bone Disorders	_____ Asthma	_____ Hepatitis	_____ HIV / AIDS

Dental History

Who is your dentist? _____

When was your last dental checkup? _____ Last Cleaning / Prophylaxis? _____

Have you ever had a thumb or finger sucking habit? _____ If yes, until what age? _____

Have you had orthodontic treatment previously? _____ If yes, when? _____ Where? _____

Do you have any speech problems? _____ Are you a mouth breather? _____

Signature: _____ Date: _____

Doctor Signature: _____ Date: _____