Patient Acquaintance Card

Patient Information

Date _____ / _____ / _____

Name _____ Preferred Name _____ Age _____ Sex _____
Last First Initial

Home Address: _____
Street City State Zip

Phone: (H) (_____)_____ (C) (_____)_____ (W) (_____)_____

Email: _____ Date of Birth _____ / _____ / _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

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

Who is financially responsible for this account? _____ SS#_____

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? _____

Female: Have you ceased menstruation? _____ If yes, when? _____

Have you taken or are you taking hormone replacement therapy? _____

Are you pregnant or believe to be pregnant? _____

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: _____

Name_____ **Date** _____

What brings you into our office? _____
(i.e. Consult / Concern, Second Opinion)

Have you seen an orthodontist prior to this visit for a consult? If so, when and where? _____

_____

Who Suggested that you might need orthodontic treatment? _____

What do you want to improve most about your smile? _____
(i.e. Bite, Midline, Crowding, Spacing, Jaw Position)

How did you hear about us? _____
(i.e. Dentist Referral, Family/Friend Recommended, GoogleSearch, Social Media)

Who is your dentist? _____

What type of orthodontic treatment are you interested in? _____
(i.e. Invisalign, Traditional Braces, Clear Braces, Maintenance/Retainers)

Do you have a goal for treatment time frame? If so, when? _____
(i.e. Treatment done by Graduation, Wedding or Special Event)

For future appointments, would you be interested in morning appointments? _____