



# 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:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Anemia               | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Rheumatic Fever   | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> ADHD           |
| <input type="checkbox"/> Bone Disorders      | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hepatitis         | <input type="checkbox"/> HIV / AIDS     |

## Dental History

Who is your Dentist? \_\_\_\_\_

When was your last dental checkup? \_\_\_\_\_ Last Cleaning / Prophylaxis? \_\_\_\_\_

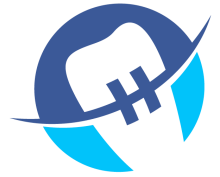
Have you ever had a thumb or finger sucking habit? \_\_\_\_\_ If yes, until what age? \_\_\_\_\_

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? \_\_\_\_\_