beach braces

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Acquaintance Form (CH/ADOL)

Patient's Name: _____ Date: _____

Date of Birth: MM__ / DD / YY Age:_____ Sex: _____ School: _____Grade: _____

Home Address: _____City: _____ Postal Code: _____ Tel: _____

Number of Children in Family: _____ Ages & Names of Other Children: _____

Patient's Dentist: _____Physician: _____ Physician's Tel:____ _____

Who may we thank for referring you? _____ Parent/Guardian's e-mail (to confirm appointments): _____

Mother's Name: _____ Home Tel: _____ Daytime Tel: _____ ☐ Work ☐ Cell ☐ Home

Father's Name: _____ Home Tel: _____ Daytime Tel: _____ ☐ Work ☐ Cell ☐ Home

Person Responsible for Account: _____ _____

Do you have an insurance plan that covers orthodontic treatment? ☐ Yes ☐ No ☐ Unsure

MEDICAL HISTORY – HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	H.I.V./A.I.D.S.	☐ Yes ☐ No	Kidney Disorder	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Hepatitis A, B, or C	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Sexually Transmitted Diseases	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No	Other: _____	

If you responded YES to any of the above, please give pertinent information: _____

_____

Is the child in good health? _____

Does the child have any history of major illness and/or operations? _____

List any drugs or medications now being taken: Please give reasons:_____

List any allergies or drug sensitivities (including sensitivity to metals) _____

Does the child have a tendency to colds? ☐ Yes ☐ No Sore Throats? ☐ Yes ☐ No Ear Infections? ☐ Yes ☐ No

Have the tonsils or adenoids been removed? ☐ Yes ☐ No _____ If so, at what age? _____

Has the patient reached puberty? Girls-Has menstruation started? ☐ Yes ☐ No Boys-Has voice changed? ☐ Yes ☐ No

DENTAL HISTORY

Has the child ever been treated for a jaw joint problem, including surgery?	☐ Yes ☐ No	Please describe_____	
Have there been any injuries to the face, mouth or teeth?	☐ Yes ☐ No	Please describe_____	
Has the child ever sucked his/her thumb or finger?	☐ Yes ☐ No	Until what age? _____	
Does the child have any speech problems?	☐ Yes ☐ No		
Does the child have frequent canker or cold sores?	☐ Yes ☐ No		
Is the child a mouth breather?	While Asleep: ☐ Yes ☐ No	While Awake:	☐ Yes ☐ No
Have you been informed of any missing or extra permanent teeth?	☐ Yes ☐ No		
Has the child ever had a previous orthodontic examination?	☐ Yes ☐ No		
Is the child especially apprehensive towards dental visits?	☐ Yes ☐ No		
Does the child want orthodontic treatment?	☐ Yes ☐ No		
Has any other family member had braces or orthodontic treatment?	☐ Yes ☐ No		

Please name the family member if treated in our office:_____

When did the child last see the family dentist? _____

List any sports, hobbies or musical instruments: _____

Reason for orthodontic treatment: _____

RELEASE OF INFORMATION: I hereby give Dr. J. Daskalogiannakis and/or members of his staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records pertaining to the initial condition, diagnosis, proposed treatment or treatment in progress.

_____ _____

Signature Date