# Orthodontic Acquaintance and Personal Information

Patient's Name: _____ Preferred Name: _____ Male/Female _____

Home Address: _____ Date of Birth: _____

_____ Home Phone: (  ) _____

POSTAL CODE

Email: _____ Cell Phone: (  ) _____

Name of General Dentist: _____

Name of Family Physician: _____

**INFORMATION FOR PATIENTS WHO ARE AGE 21 OR UNDER:**

School: _____ Grade: _____

| | **Parent** | **Parent** |
|---|---|---|
| Name: | | |
| Address & Phone No. | | |
| (if different from above): | Ph.(  ) | Ph.(  ) |
| Employer's Name: | | |
| Business Phone: | (  ) Cell Ph.(  ) | (  ) Cell Ph.(  ) |
| Occupation: | | |

Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Single ❑

Person Responsible for Payment of Account: _____

Is Patient Covered by Orthodontic Insurance? ❑ Yes ❑ No

## MEDICAL HISTORY

| | | | |
|---|---|---|---|
| Is the Patient in Good Health? | ❑ Yes | ❑ No | Reason: _____ |
| Any Major or Unusual Illnesses? | ❑ Yes | ❑ No | Explain: _____ |
| Currently Under Physician's Care? | ❑ Yes | ❑ No | Reason: _____ |
| Currently Taking Medication? | ❑ Yes | ❑ No | List: _____ |
| Allergies? | ❑ Yes | ❑ No | List: _____ |
| Drug Sensitivity? | ❑ Yes | ❑ No | List: _____ |

**Please Check if the Patient Has or Had Any of the Following:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Anaemia | ❑ | ❑ | Heart Disease | ❑ | ❑ | Frequent Colds and/or |
| ❑ | ❑ | Blood Disease | ❑ | ❑ | Tuberculosis | ❑ | ❑ | Tonsilitis |
| ❑ | ❑ | Prolonged Bleeding | ❑ | ❑ | Diabetes | ❑ | ❑ | Adenitis |
| ❑ | ❑ | Hepatitis | ❑ | ❑ | Endocrine Problems | ❑ | ❑ | Tonsils Removed Age: _____ |
| ❑ | ❑ | HIV +ve /AIDS | ❑ | ❑ | Bone Disorders | ❑ | ❑ | Adenoids Removed Age: _____ |
| ❑ | ❑ | Jaundice | ❑ | ❑ | Epilepsy | ❑ | ❑ | Asthma |
| ❑ | ❑ | Rheumatic Fever | ❑ | ❑ | Herpes/Cold Sores | ❑ | ❑ | Mouthbreathing While Awake ❑ While Asleep ❑ |

**GROWTH INFORMATION FOR PATIENTS UNDER 16 YEARS OF AGE**

Father's Height _____ Mother's Height _____ Adopted? Yes ❑ No ❑

Patient Resembles: ❑ Neither Parent ❑ Mother ❑ Father

GIRLS: Has She Started Menstruation? ❑ Yes ❑ No When? _____

BOYS: Has His Voice Changed? ❑ Yes ❑ No When? _____

Names and Ages of Patient's Brothers and Sisters: _____

Have Any Had Orthodontic Treatment? ❑ Yes ❑ No Who? _____

## DENTAL HISTORY

| Yes | No | |
|---|---|---|
| ❑ | ❑ | Has the Patient Had Any Severe Head or Face injuries? _____ |
| ❑ | ❑ | Has the Patient Had a History of Thumbsucking or Fingersucking? Age Stopped? _____ |
| ❑ | ❑ | Does the Patient Play Any Musical Instruments? What? _____ |
| ❑ | ❑ | Has the Patient Consulted an Orthodontist Previously? |
| ❑ | ❑ | Has the Patient Had Any Previous Orthodontic Treatment? |

**Please Check if There is a History of:**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ❑ | ❑ | Clenching Teeth | ❑ | ❑ | Jaw Joint Soreness |
| ❑ | ❑ | Grinding Teeth | ❑ | ❑ | Jaw Joint Clicking |
| ❑ | ❑ | Headaches (More than Normal) | ❑ | ❑ | Jaw Joint Popping |
| ❑ | ❑ | Muscular Soreness Around Head and Neck | ❑ | ❑ | Ringing in Ears |

Is There Any Other Information That May be Helpful? _____

Reason for this Orthodontic Consultation? _____

*Thank You*

Signed: _____ Date: _____