Pediatric Dentistry
& Orthodontics
www.pdgdental.com

Dr. Donal C. Flanagan
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Certified Specialists in Orthodontics

Orthodontic Acquaintance Form

Patient Name: ______________________ Email: ______________________

Date of Birth: ____________ (MM/DD/YYYY) Age: ____________ Gender Identity: ☐Female ☐Male

Home Address: ______________________

Phone Number: ______________ Who may we thank for referring you? ______________

Patient's Dentist: ______________ Last Appointment Date: ______________

Patient's Physician: ______________ Physician's Tel: ______________

Patient's Occupation: ______________________

Person Responsible for the Account: ______________ Relationship: ______________

Is the Patient Covered by Orthodontic Insurance? ☐Yes ☐No

Emergency Contact: ______________ Phone Number: ______________

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

- ☐Frequent Colds
- ☐Rheumatic Fever
- ☐Heart Murmur/Heart Disease
- ☐Prolonged bleeding/Blood disease
- ☐Learning/Behavioral Condition
- ☐Liver Disease/Jaundice
- ☐Kidney Disorder
- ☐Leukemia/Cancer
- ☐Endocrine Problems
- ☐H.I.V/ A.I.D.S.
- ☐Hepatitis A, B, or C
- ☐Diabetes
- ☐Epilepsy
- ☐Bone Disorders
- ☐ADD/ADHD
- ☐Autism Spectrum
- ☐Emotional Disorder
- ☐Artificial Heart Valve
- ☐Eczema
- ☐Vision Problems
- ☐Mouthbreathing
- ☐Tuberculosis
- ☐Asthmas
- ☐Tonsillitis
- ☐Adenoids
- ☐ Other
- ☐**None of the above**

If you checked off any of the above please give pertinent details: ______________________

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Are you currently being treated for any medical conditions? ______________________

List any drugs or medications being taken (Please give reason): ______________________

Do you have any history of major illness and/or operations?: ______________________

List any allergies or drug sensitivities: ______________________ ☐ Latex

Have tonsils or adenoids been removed? If so at what age?: ______________________

Do you have a tendency to colds, sore throats, or ear infections? (Please list): ______________________

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(over please...)

DENTAL HISTORY

Have you ever been treated for a jaw joint problem, including surgery? ☐Yes ☐No

Have there been any injuries to the face, mouth, teeth? Please describe: ☐Yes ☐No

____

Have you had a history of thumb-sucking or finger-sucking? Age stopped? ☐Yes ☐No Age: _______

Do you have any speech problems? ☐Yes ☐No

Are you a mouth breather? ☐Yes ☐No Awake/Asleep

Have you consulted an orthodontist previously? ☐Yes ☐No

Have you had any previous orthodontic treatment? If yes, please clarify: ☐Yes ☐No

____

PLEASE CHECK IF THERE IS A HISTORY OF:

☐Clenching teeth
☐Grinding teeth
☐Headaches (more than normal)
☐Muscular soreness around head and neck
☐Jaw joint popping
☐Ringing in ears
☐Jaw joint soreness
☐Jaw joint clicking

Is there other information that may be helpful? ______________________________

Reason for this orthodontic consultation: ______________________________

I hereby give Dr. Donal Flanagan and/or Dr. Christian Wong and/or Dr. Todd Moore and/or members of their 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 which pertain to the initial condition, diagnosis, proposed treatment plan or treatment in progress.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

____
Patient's Signature

______________________________ ______________________________
Printed Name Date

Thank you!