PDG Pediatric Dentistry & Orthodontics
www.pdgdental.com

Dr. Donal C. Flanagan
Dr. Christian A. Wong
Dr. Todd R. Moore
Certified Specialists in Orthodontics

Child Orthodontic Acquaintance Form

Patient Name: _____ Email: _____

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

Home Address: _____

Number of children in the family: _____ Ages and Names of other Children: _____

Patient's Dentist: _____ Who may we thank for referring you? _____

Patient's Physician: _____ Physicians Tel: _____

Parent/Guardian's Name: _____ Home Tel: _____ Daytime Tel: _____

Parent Occupation: _____ Email Address: _____

Parent/Guardian's Name: _____ Home Tel: _____ Daytime Tel: _____

Parent Occupation: _____ Email Address: _____

Parental Relationship: ☐Married ☐Widowed ☐Separeted ☐Divorced ☐Single ☐Common Law

Person Responsible for the Account: _____

MEDICAL HISTORY- HAS THE CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

☐Frequent Colds	☐Kidney Disorder	☐Epilepsy	☐Tuberculosis
☐Rheumatic Fever	☐Leukemia/Cancer	☐ADD/ADHD	☐Asthmas
☐Heart Murmur/Heart Disease	☐Endocrine Problems	☐Autism Spectrum	☐Bone disorders
☐Prolonged bleeding/Blood disease	☐H.I.V/ A.I.D.S.	☐Emotional Disorder	☐Other
☐Learning/Behavioural Condition	☐Hepatitis A, B, or C	☐Artificial Heart Valve	☐**None of the Above**
☐Liver Disease/Jaundice			

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

_____

Is the child being treated for any other medical conditions?: _____

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

Does the child 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?: _____

Does the child have a tendancy to colds, sore throats, or ear infections? (Please list): _____

_____

(over please...)

DENTAL HISTORY

Has the child 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	
Has the child ever sucked his/her thumb or finger? If so until what age?	☐Yes	☐No	
Does the child have any speech problems?	☐Yes	☐No	
Does the child get frequent canker or cold sores?	☐Yes	☐No	
Is the child a mouth breather?	☐Yes	☐No	Awake/Asleep
Have you been informed of any missing or extra permanent teeth?	☐Yes	☐No	
Is the child especially apprehensive towards dental visits?	☐Yes	☐No	

Please name any family members treated in our office: _____

When did the child last see the family dentist? _____

I hereby give Dr. Donal Flanagan and/or Dr. Christian Wong and/or Dr. Todd Moore and/or members of their staff pemission 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.

_____ _____

Signature of Parent or Legal Guardian Date

_____

Printed Name

_____ _____

Update Date

Thank you!

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