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SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS
SPECIALIST IN PEDIATRIC DENTISTRY

SM#________

YOUTH/ADOLESCENT ORTHODONTIC ACQUAINTANCE FORM

Child's Name: ________________________________ Sex: _______ Date of Birth: ___/___/_____ Age: ___
Address: ________________________________ ________________________________
City: ____________ State:_______ Zip:________ **Email Address**: ________________________
School: ________________________________ Interests or Hobbies: ____________________
Primary Phone Number _______________ ______ Child Lives With: ______________________
Responsible Financial Party:__________________ Dental Insurance: ______________________

Guardian 1: ________________________________ Relationship to Child ____________________
Date of Birth: ______________________________ Guardian's Social Security: ______________
Employed by: _______________________________ Occupation: ___________________________
Bus. Address: ______________________________ Home Address: _________________________
Bus. Phone:_________________________________ Cell Phone:____________________________
Drivers license: _____________________________ **Email Address** _______________________

Guardian 2: ________________________________ Relationship to Child ____________________
Date of Birth: ______________________________ Guardian's Social Security: ______________
Employed by: _______________________________ Occupation: ___________________________
Bus. Address: ______________________________ Home Address: _________________________
Bus. Phone:_________________________________ Cell Phone:____________________________
Drivers license: _____________________________ **Email Address** _______________________

Physician: __________________________________ City: ____________ Phone:_______________
Dentist: ____________________________________ City: ____________ Phone:_______________

WHOM MAY WE *THANK* FOR REFERRING YOU TO US? ____

MEDICAL HISTORY

Is your child in good health? ☐ Yes ☐ No ____
Approximate date of last physician visit and why? ☐ Yes ☐ No ____________________________
Has your child ever had a serious illness? ☐ Yes ☐ No _________________________________
Have adenoids or tonsils been removed? ☐ Yes ☐ No If yes, what age? ____________________

Check any of the following conditions currently present or in past history:

☐ AIDS OR HIV POSITIVE	☐ ASTHMA	☐ EPILEPSY
☐ DIABETES	☐ KIDNEY INVOLVEMENT	☐ LIVER INVOLVEMENT
☐ HEART TROUBLE	☐ GLAUCOMA	☐ ARTHRITIS OR JOINT DISEASE
☐ RHEUMATIC FEVER	☐ ENDOCRINE PROBLEMS	☐ EMOTIONAL PROBLEMS
☐ BONE DISORDERS	☐ PROLONGED BLEEDING	☐ NERVOUS DISORDER
☐ HEPATITIS	☐ TUBERCULOSIS	☐ FAINTING OR DIZZINESS
☐ LATEX ALLERGIES	☐ DENTAL PHOBIA	☐ SENSITIVE GAG REFLEX

Comments, including other illnesses we should know about: ____________________________________
____
____
____

(Please turn page over)

Does your child have any physical or mental disabilities or handicaps? Yes ☐No ☐Explain: ________________________
____
____

Please list all prescription drugs or medications taken in the last 3 months (give reason): ___________________________
____
____

List all allergies or drug sensitivities:____
____

DENTAL HISTORY

When was your child's last dental visit (approximate date?) ___/___/_____
Was all recommended dental work completed? .... ☐Yes ☐No
Have there ever been any injuries to the face, mouth, or teeth? .... ☐Yes ☐No
Does your child brush his or her teeth 3 times a day? .... ☐Yes ☐No
Does he or she floss daily? .... ☐Yes ☐No
Does your child have any missing or extra permanent teeth? .... ☐Yes ☐No
Has your child ever noticed pain, clicking sounds, or locking in the jaw joint? .... ☐Yes ☐No

HABITS AND PERSONALITY

Does your child have any of these habits:
☐Thumb or finger sucking ☐Mouth breathing ☐Tongue thrust (abnormal swallowing) ☐Clenching or grinding teeth
☐Other Oral habits ____
Child's ability to follow through with responsibilities (homework, housework, etc.?) Excellent ☐ Fair ☐ Poor ☐

Please check all the words which seem to best describe your child:

☐ Calm	☐High-Strung	☐Spoiled	☐Active	☐Cooperative
☐ Moody	☐Curious	☐Fearful	☐Defiant	☐Shy
☐ Talkative	☐Compulsive	☐Friendly	☐Sympathetic	☐Temper Tantrums
☐ Leader	☐Quiet	☐Task oriented	☐People Oriented	☐Helpful

What is your child's attitude towards orthodontic treatment: ☐Eager ☐Disinterested ☐Hostile

GROWTH AND DEVELOPMENT

Is your child adopted? .... ☐ Yes ☐ No
Have you ever been told your child has a growth problem? .... ☐ Yes ☐ No

ORTHODONTIC HISTORY

Please describe your child's orthodontic problems as you see it:____
Are you pleased with his or her facial profile?.. ☐ Yes ☐ No
Has an orthodontist been consulted previously? .... ☐ Yes ☐ No
Has your child ever had past orthodontic treatment? _____ If so, who treated your child? ___________________________
Does anyone in the family have a similar dental or facial condition? .... ☐ Yes ☐ No
What would you like orthodontic treatment to accomplish? ____
____ -

CONSENT

Your child is a minor: it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including diagnostic radiographs. If my child ever has a change in his/her health or medications, I will inform the doctor at the next appointment without fail.

Date:_______________ **Name:** ______________________________ **Signature:** ____

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