ORTHODONTIC ACQUAINTANCE CHART

Nick name _____ Date _____

Patient's name _____ Birth date _____ Age _____

Home address _____ (street) _____ (city) _____ (zip) Phone ( ) _____

No. of children in family _____ Patient's Physician _____ Dentist _____

School _____ Grade _____ Who referred you to our office? _____

Father's name _____ (first) Occupation _____ Employed by _____

Business address _____ (street) _____ (city) Phone _____

Mother's name _____ (first) Occupation _____ Employed by _____

Business address _____ (street) _____ (city) Phone _____

Are parents divorced? _____ Separated? _____ Widowed? _____

Person financially responsible _____ Relationship _____

Dental Insurance? _____ Social Security No. _____ Union or other plan? _____

MEDICAL HISTORY (circle yes or no and fill in blanks where required)

1. Is the patient in good health? _____ Yes No
2. Date of last dental exam _____ Is work completed? _____ Yes No
3. Have full mouth x-rays ever been taken? If yes, give date _____ No Yes
4. Have tonsils and/or adenoids been removed? At what age? _____ Yes No
5. Has patient reached puberty? _____ No Yes
6. Are height and weight normal for age? _____ Yes No
7. Frequent colds, sore throat, or ear infections? _____ No Yes
8. Any history of major illness? If yes, list _____ No Yes
9. Any allergies or drug sensitivity? If yes, list _____ No Yes
10. Taking medication now? If yes, list _____ No Yes
11. Under medical care now? Reason _____ No Yes

_____

12. Circle any of the following for which the patient has been treated:

Diabetes	Asthma	Prolonged bleeding	Tonsillitis
Arthritis	Epilepsy	Nervous disorders	Brain injury
Heart trouble	Rheumatic fever	Endrocrine problems	Tuberculosis

DENTAL HISTORY (circle answer)

13. Have there been any injuries to the face, mouth, or teeth? _____ No Ye
14. Has patient ever sucked thumb or fingers? Until what age? _____ No Ye
15. Has patient ever had oral habits, such as lip biting or tongue thrusting? _____ No Ye
16. Any finger nail biting? _____ No Ye
17. Does patient have any speech problems? _____ No Ye
18. Has patient have any speech problems? _____ No Ye
19. Is the patient a mouth breather while asleep or awake? _____ No Ye
20. Are you aware of any missing or extra permanent teeth? _____ No Ye
21. Has an orthodontist been consulted previously? _____ No Ye
22. Have either parent or other children had orthodontic treatment? _____ No Ye
23. Would you consider the patient's diet high in sweets? _____ No Ye
24. List any musical instruments played _____ How long? _____
25. What are you most concerned about? _____

_____

26. What is your dentist most concerned about? _____
27. Person filling out this form _____ Relationship _____

RICHARD C. KARDOVICH, DDS, P.C.