CHILD/ADOLESCENT ACQUAINTANCE FORM

DATE __________ 20 __________

DATE OF BIRTH __________

PATIENT'S NAME __________ (Last) __________ (First) INITIAL __________ AGE __________ SEX __________

RES. ADDRESS __________ ZIP __________ TELEPHONE __________

SCHOOL __________ GRADE __________ NICKNAME __________

PATIENT'S DENTIST __________ PHYSICIAN __________

REFERRED BY __________

FATHER'S NAME __________ CELL PHONE __________

OCCUPATION __________ SOCIAL SECURITY NUMBER __________

EMPLOYED BY __________ BUS. TELEPHONE __________

MOTHER'S NAME __________ CELL PHONE __________

OCCUPATION __________ SOCIAL SECURITY NUMBER __________

EMPLOYED BY __________ BUS. TELEPHONE __________

NAMES AND AGES OF OTHER CHILDREN IN FAMILY __________

____

DO YOU HAVE DENTAL INSURANCE? __________ IF YES, WITH WHOM? __________

MEDICAL HISTORY

DOES PATIENT HAVE ANY HISTORIES OF MAJOR ILLNESS? __________

PLEASE LIST ALLERGIES: __________

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- ☐ **DIABETES**
- ☐ **PNEUMONIA**
- ☐ **HEART TROUBLE**
- ☐ **MITRAL VALVE PROLAPSE**
- ☐ **BONE DISORDERS**
- ☐ **TUBERCULOSIS**
- ☐ **ANEMIA**
- ☐ **EPILEPSY**
- ☐ **ASTHMA**
- ☐ **ARTIFICIAL JOINTS**
- ☐ **HEPATITIS**
- ☐ **PROLONGED BLEEDING**
- ☐ **FAINTING OR DIZZINESS**
- ☐ **NERVOUS DISORDERS**
- ☐ **RHEUMATIC FEVER**

DOES THE PATIENT HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? YES ☐ NO ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS: __________

LIST ANY ALLERGIES OR DRUG SENSITIVITY: __________

HAS THE PATIENT REACHED PUBERTY? GIRLS-----HAS SHE STARTED MENSTRUATION YES ☐ NO ☐

BOYS------HAS HIS VOICE CHANGED YES ☐ NO ☐

HEIGHT__________ WEIGHT__________

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? __________ YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? __________ YES ☐ NO ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? __________ YES ☐ NO ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? __________ YES ☐ NO ☐

WHILE ASLEEP? __________ YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH __________ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? __________ YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT __________ YES ☐ NO ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED: __________ YES ☐ NO ☐

REASON FOR CONSULTATION __________

____

E-MAIL __________ __________

Parent's Signature

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