



Child Orthodontic Acquaintance Card
(please print)

Patient's Name _____ Date _____
Nickname _____ Sex _____ Age _____ Birthdate _____
Address _____ School _____
City _____ ZIP _____
Email _____ Phone _____ Grade _____

PARENTS AND ACCOUNT INFORMATION

Parent's Marital Status: Married Separated Divorced Widowed

Father

Mother

Name: _____
Address (if different from above): _____
Phone (if different from above): _____
Social Security Number: _____
Birth Date: _____
Employer's Name: _____
Business Address: _____
Business Phone: _____
Occupation: _____
Person Responsible for Account: _____
Email Address: _____

If other than parent:

Name: _____ Address: _____ Phone: _____

Does your insurance cover orthodontics? YES NO

INSURANCE INFORMATION

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. For your convenience, we will gladly submit insurance claims pertaining to any charge for care in our office.

Policy holder's name _____ Soc. Sec. No. _____
LAST FIRST MIDDLE

Policy holder's Date of Birth _____

Insurance Co. _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? YES NO if yes:

Policy holder's name _____ Soc. Sec. No. _____

Insurance Co. _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

DENTAL HISTORY

Dentist: _____

Date of the last dental exam: _____

Has the patient been told of:

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| Unfinished Dental Care | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Thumb/finger sucking | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Tongue thrusting | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Mouth breathing | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Teeth grinding/clenching | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Missing or extra permanent teeth | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Ear infections | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Gum Disease | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Fear of treatment | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

Has your child ever been injured in the mouth or face?
YES NO

Have tonsils and adenoids been removed?
YES NO

Have any primary or permanent teeth been extracted?
YES NO

Comments: _____

Why did you seek this orthodontic consultation? _____

Who referred you? _____

Have you ever been examined by an orthodontist before?

YES NO

Is the patient interested in having orthodontic treatment?

YES NO

Has any other family member had orthodontic treatment?

YES NO

Relatives or friends treated here?

YES NO

Who? _____

Is there any other information that may be helpful for your treatment today _____

MEDICAL HISTORY

Physician: _____

Is the patient in good health? YES NO

Has the patient seen a physician in the last 2 years?
YES NO

What was the reason for the visit? _____

List any drugs or medications now being taken?

List any allergies or sensitivity? _____

Does the patient wear contact lenses? YES NO

Does your child take any medication for bone density?
YES NO

Check any of the following for which the patient has been

treated:

Diabetes YES NO

Hepatitis YES NO

Heart Trouble YES NO

Glaucoma YES NO

Rheumatic Fever YES NO

High Blood Pressure YES NO

Bone Disorders YES NO

Prolonged Bleeding YES NO

Thyroid Disorders YES NO

Fainting/Dizziness YES NO

Tuberculosis YES NO

Epilepsy YES NO

Anemia YES NO

Asthma YES NO

Arthritis YES NO

Head & Neck Pain YES NO

Immunity Disorders YES NO

AIDS YES NO

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Phone _____ Relationship _____

AUTHORIZATION RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Reviewed by: _____

Signature _____

Date _____