



Orthodontic Treatment for Adults & Adolescents

Child Orthodontic Acquaintance Card (please print)

Patient's Name _____ Date _____

Nickname _____ Sex _____ Age _____ Birthdate _____

Address _____ School _____

City _____ ZIP _____ Phone _____ Grade _____

Mother's Name _____ Occupation _____

Employed by _____ # of years _____ Work Phone _____

Father's Name _____ Occupation _____

Employed by _____ # of years _____ Work Phone _____

Person responsible for payment _____ Soc. Sec. No. _____

Address _____ City _____ ZIP _____

Patient's Dentist _____

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? _____

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 any charge for care in our office.

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

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 _____

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

Check any of the following for which the patient has been treated:

Diabetes	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Hepatitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Trouble	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Glaucoma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rheumatic Fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
High Blood Pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bone Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Prolonged Bleeding	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Thyroid Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fainting/Dizziness	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Tuberculosis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Epilepsy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Anemia	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Asthma	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Arthritis	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Head & Neck Pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Immunity Disorders	YES <input type="checkbox"/>	NO <input type="checkbox"/>
AIDS	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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

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: _____

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.

Signature _____ Date _____ Reviewed by: _____