

CHILD ORTHODONTIC ACQUAINTANCE SHEET

MONTGOMERY PEDIATRIC DENTISTRY P.C.

Date _____ 20 _____ Date of Birth _____ Age _____ Sex _____

Patient's Name _____ Name Patient Goes By _____ Child's S.S.# _____

Home Address _____ City _____ Zip _____ Telephone _____

School _____ Grade _____

Whom may we thank for referring you to our office? _____

PARENT / GUARDIAN INFORMATION

Parent's Marital Status Married Widowed Divored Separated Single

Father's Name _____

Mother's Name _____

Date of Birth _____ SS# _____

Date of Birth _____ SS# _____

Drivers License# _____ State _____

Drivers License# _____ State _____

Occupation _____

Occupation _____

Employed By _____

Employed By _____

Address _____

Address _____

Business Telephone _____ Ext. _____

Business Telephone _____ Ext. _____

Dental / Ortho Ins. _____

Dental / Ortho Ins. _____

Group Number _____

Group Number _____

Contact Number _____

Contact Number _____

Responsible Party _____

Billing Address if different from residence _____

GENERAL APPRAISAL

What concerns you most about your child's teeth? _____

Other children with similar Orthodontic problems and age _____

Parents or grandparents with similar problem _____

Has any member of your family received orthodontic treatment _____

Will patient cooperation be Excellent Good Fair Poor Indifferent

Patient's attitude toward receiving orthodontic treatment _____

Date of last dental check-up _____

MEDICAL HISTORY

Is patient in good health? _____

Does Patient have any history of major illness? _____

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

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Liver Involvement |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Allergies |

Does Patient have a 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

DENTAL HISTORY

Have there been any injuries to face, mouth, or teeth? _____ Yes No

Has Patient ever sucked thumb or fingers? Until what age? _____ Yes No

Does 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

List any musical instruments played _____

ACCOUNT RESPONSIBILITIES

Person responsible for Account _____ S.S.# _____

Address if different from patient _____

Employed by _____ Business Telephone _____

Do you have orthodontic Insurance? _____ Yes

No

Initial _____ I authorize this office to obtain a credit report.

Initial _____ I agree to be financially responsible for any and all charges for services rendered by this office.

Initial _____ I further understand I am responsible for any collection agency and/or attorney fees, if those services are required to collect for any services provided by this office.

Responsible Party Signature/ Relation to Patient