ORTHODONTIC ACQUAINTANCE SHEET

Date: _____

Name: _____ Date of Birth: _____

Sex: M/F Address_____ (Street, P. O. Box)
_____ (City, Town, Community)
_____ (Postal Code)
Home#: _____ Work#:_____ Cell#:_____

Parent/Guardian Information (if applicable):
Mother's Name_____H#:_____W#:_____ C#:_____
Father's Name_____H#:_____W#:_____ C#:_____

For appointment reminders and access to your online account, please provide the parent/guardian (if applicable) or patient's e-mail address: _____

MEDICAL AND DENTAL HISTORY:

Please circle which conditions you have or have been treated for:

Diabetes Type I /Type II Asthma Epilepsy Heart conditions

Bone disorders Blood/bleeding disorders Immune Suppression

Please list ALL current and recent medications below:
Medication: _____ Reason: _____
Medication: _____ Reason: _____
Medication: _____ Reason: _____

Please list any current or previous major illnesses that were not mentioned above:
_____

Please ensure that you have included All medications & treatments including bisphosphonates, chemotherapy, radiotherapy, corticosteroid and any immune suppressants.

Any allergies to medications? Y N If yes, please indicate: _____

Any allergies to metals or latex? Y N If yes, please indicate: _____

Do you require antibiotics prior to dental appointments? Y N

Have your tonsils and/or adenoids been removed? Y N

Have there been any injuries to the face, mouth or teeth? Y N

Have you ever had a thumb/finger sucking habit? Y N

Are you aware of any speech problems that you would like to address? Y N

When was your last dental check-up (i.e. examination for cavities, etc.)?_____

Have you had a previous orthodontic consultation? Y N If yes, when? _____

Have any of your family members been seen for a consultation &/or received orthodontic care in our office? If so please state name(s): _____

Name of your regular Dentist: _____