CHILD ORTHODONTIC ACQUAINTANCE PATIENT INFORMATION

Patients Name:_____ **Preferred Name:**_____
First Middle Last

Address:_____
Street City State Zip

Birthdate: _____ **Age:** ____ **Gender:** M or F **School:** _____ **Grade:** _____
General Dentist: _____ **Office Number:** _____ **Last Visit Date:** _____

Whom may we thank for recommending our office to you? _____
What do you think is your orthodontic problem? _____
What do you hope orthodontics will accomplish? _____

RESPONSIBLE PARTY INFORMATION

Name of person responsible for account (if other than above patient): _____
Address:_____
Street City State Zip

Cell Phone:_____ **Home:**_____ **Email:** _____
Social Security #:_____**Birthdate:**_____ **Relationship to patient:** _____
Ins. Company Name: _____**Member or Enrollee ID#:**_____**Group #:**_____
Employer: _____**Occupation:** _____ **# of Years Employed:** _____

Name of person to call for treatment updates/ appt. reminders (if other than above)**:** _____
Relationship: _____ **Cell Phone:** _____ **Home Phone:** _____ **Email:** _____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____
Complete Adress:_____Phone#: _____

MEDICAL HISTORY

Are you in good health?	____ Yes ____ No	Explain:_____
Any major or unusual illnesses?	____ Yes ____ No	Explain:_____
Currently being treated by a physician?	____ Yes ____ No	Reason:_____
Currently taking medication?	____ Yes ____ No	Reason:_____
Allergies	____ Yes ____ No	List:_____
Drug sensitivity	____ Yes ____ No	List:_____

Please check if patient has or has had any of the following:

____ Anemia	____ Heart Problems	____Frequent Colds or Flu	____Are you in a risk group for Aids? ____
____ Blood Disease	____ Tuberculosis	____Tonsillitis	____ Tonsils Removed: Age: ____
____ Prolonged Bleeding	____ Diabetes	____Hepatitis	____Adenoids Removed: Age:____
____Jaundice	____ Endocrine Problems	____ Asthma	____Mouth Breathing: While awake? ____
____ Rheumatic Fever	____ Bone Disorders	____ Epilepsy	While asleep? ____
____ Herpes	____Glaucoma	____Adenoiditis	

DENTAL HISTORY

YES	NO	
___	___	Have you ever had any severe head or face injuries? Explain:_____
___	___	Have you had a history of thumb sucking or finger sucking? Age Stopped:_____
___	___	Do you play any musical (wind) instruments? What:_____
___	___	Have you consulted an orthodontist previously?
___	___	Have you had any previous orthodontic treatment?
___	___	Have any family members had orthodontic treatment?

Please check if there is a history of:
_____ Clenching Teeth _____ Grinding Teeth _____ Headaches (more than normal) _____ Jaw Joint Popping _____ Jaw Joint Soreness
_____ Ringing in the Ears _____ Muscular Soreness around Head and Neck _____ Jaw Joint Clicking

Is there any other information that may be helpful?_____
I give Dr. Aileen Wang permission to file insurance claims and receive payment directly

Signed:_____ **Date:**_____