CHILD ORTHODONTIC ACQUAINTANCE FORM

Name:____

Date of Birth: (D/M/Y)________________________ Age: __________________________ Sex: Male / Female

School and Grade: ____

Home Address: _______________________________________City: _____________ Postal Code: __________

Telephone: (______) ________________ Sibling Names + Ages : ____

Email Desired for contact: ____

Patient's Dentist: ______________________________ Referred by:______________________________________

Person responsible for account: ____________________Other Parental consent required: ____________________

Mother's name: ____ Business Tel: ____________________

Father's name: ____ Business Tel: ____________________

Do you have an insurance plan that covers orthodontic treatment? (please circle) Yes No Unsure

Reason for orthodontic consultation? ____

MEDICAL HISTORY

Has the child ever been treated for any of the following?

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Murmur			**Artificial Joints (Hip, Knee, etc.)**			**High Blood Pressure**			**Kidney Disorder**		
Mitral Valve Prolapse			**Tuberculosis**			**Blood Disease**			**Asthma**		
Rheumatic Fever			**Radiation Therapy**			**Anemia**			**Arthritis**		
Heart Disease			**H.I.V./A.I.D.S.**			**Prolonged Bleeding**			**Thyroid Disorders**		
Artificial Heart Valve			**Diabetes**			**Hepatitis A, B, or C**			**Other:**		
			Endocrine Problems								

If YES to any of the above, please give pertinent information:__________________________

____

Family Physician:_________________________________ Tel No:(_____) ___________ Is the child in good health? Yes / No

Does the child have any history of major illnesses and/or operations?____

____

List any drugs or medication now being taken: Please give reasons: ____

____

List any allergies or drug sensitivities: ____

Does the child have a tendency to colds? Yes / No Sore throats? Yes / No Ear infections? Yes / No

Have tonsils or adenoids been removed? Yes / No If yes, when ? ____

Has the patient reached puberty? **Girls**: started menstruation? Yes / No **Boys**: voice changed yet? Yes / No

DENTAL HISTORY (Please circle)

Have there been any injuries to the face, mouth, or teeth ?	YES	NO
Has the child ever sucked a thumb or finger? Until what age ?_________________	YES	NO
Does the child have any speech problems ?	YES	NO
Does the child have frequent canker or cold sores ?	YES	NO
Is the child a mouth breather ? (If yes please circle): While asleep ? or awake ? or both ?	YES	NO
Have you been informed of any missing or extra baby or permanent teeth ?	YES	NO
Has the child ever been treated for a jaw joint problem, including surgery ?	YES	NO
Has the child ever had a previous orthodontic examination ? With whom ? ________________	YES	NO
Has anyone else in the family had orthodontic treatment ?	YES	NO
Does the child want orthodontic treatment ?	YES	NO

When did the child last see the family dentist ?____

List any musical instruments or sports played and hobbies ____

I hereby consent that Dr. Ziedenberg may release any information to my insurance carrier and/or Dentist as may be necessary for complete treatment of the above named patient. I hereby certify that the above information is complete and correct to the best of my knowledge.

Parent or Guardian's Signature: ____ **Date:** __________________________