CHILD ORTHODONTIC ACQUAINTANCE FORM

Name:_____

Date of Birth: (D/M/Y)_____ Age: _____ Sex: Male / Female / Other

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: _____

Parent name: _____ Business Tel: _____

Parent 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:** _____