

ORTHODONTIC ACQUAINTANCE CARD

Date _____

Date of Birth _____

ABOUT YOUR CHILD

Patient's Name _____ Nickname _____ Age _____ Sex _____

Home Address _____ Phone () _____

City _____ Zip _____ School _____

Special interests, sports or hobbies: _____

Who may we thank for sending you to our office? _____

Family members who have been patients with Drs. Pair: _____

ABOUT YOU

Father _____ D.O.B. _____

Mother _____ D.O.B. _____

Address _____ Home # _____

Address _____ Home # _____

City _____ Zip _____

City _____ Zip _____

Occupation _____

Occupation _____

Employer _____

Employer _____

Bus. Phone # _____ Cell # _____

Bus. Phone # _____ Cell # _____

Social Security # _____

Social Security # _____

Drivers License # _____

Drivers License # _____

Person responsible for Account _____

E-mail _____

IF YOU HAVE ORTHODONTIC INSURANCE, PLEASE COMPLETE INFORMATION BELOW:

DENTAL INSURANCE COMPANY #1

DENTAL INSURANCE COMPANY #2

Dental Ins. Co.: _____

Dental Ins. Co.: _____

Their phone #: _____

Their phone #: _____

Group #: _____

Group #: _____

This Dental Insurance is provided through:

This Dental Insurance is provided through:

Their name: _____

Their name: _____

Relationship to child: _____

Relationship to child: _____

Their Soc. Sec. #: _____

Their Soc. Sec. #: _____

Their Birthdate: _____

Their Birthdate: _____

Their Employer: _____

Their Employer: _____

DENTAL/MEDICAL HISTORY

Has your child ever had any of the following medical conditions or problems:

PLEASE CIRCLE:

- | | | | |
|--------------------------------|------------------------|-----------------|---------------------|
| Y N Heart Murmur | Y N Gagger | Y N Glaucoma | Y N Rheumatic Fever |
| Y N Heart problems of any kind | Y N Hemophilia | Y N Migraines | Y N Hepatitis |
| Y N Convulsions / Epilepsy | Y N Bleeding Problems | Y N Cancer | Y N Asthma |
| Y N ADD/ADHD/Hyperactive | Y N Hearing Impairment | Y N Diabetes | Y N Latex Allergy |
| Y N Any stays in hospital | Y N Any Operations | Y N HIV + /AIDS | |

DOES YOUR CHILD NEED TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N

Are there any other medical conditions or problems relating to your child? Y N If yes, please list: _____

Is your child currently under the care of a physician? Y N

Child's physician: _____ Their phone #: _____ The approx. date of last visit: _____

IS YOUR CHILD ALLERGIC TO ANY DRUGS? Y N If yes, please list: _____

Is your child taking any prescription drugs? Y N If yes, please list: _____

Child's dentist: _____ Their phone #: _____ The approx. date of last visit: _____

PLEASE CIRCLE:

- Have there been any injuries to the face, mouth or teeth? Y N
- Has your child ever sucked his/her thumb or fingers? Y N Until what age? _____
- Does your child have any speech problems? Y N Is your child a mouth breather? Y N
- Has your child had tongue-thrust or speech therapy? Y N Have you ever been informed of any missing or extra teeth? Y N
- Has an orthodontist been consulted previously? Y N Who? _____
- Have you been told your child has TMJ (Temporomandibular Joint) problems? Y N Has your child's jaw ever locked open? Y N
- Does your child's jaw joint ever make noise (cracking or popping sound) when chewing or yawning? Y N

WHAT DO YOU WANT ORTHODONTIC TREATMENT TO ACCOMPLISH? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

Parent or Guardian's signature _____ Date: _____