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Get Acquainted Questionnaire

For Patients Under 18 Years of Age

The Following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's Full Name ______________________________________ Nickname ____________________

Age ________ Birthday__________ Sex *Male Female* Height ___________ Weight _______

Whom may we thank for referring you to our office? _______________________________________

School ____________________________ Grade________

Like or Dislike School? Musical Instrument Played ____________________

Favorite Sports, Hobbies, & Avocations :____

INSURANCE COVERAGE:

Insurance: _________________________

Employer_________________________________

Subscriber Name___________________________

Policy Number _____________DOB________

SS#______________________________________

INSURANCE COVERAGE: *Yes No*

Insurance: _________________________

Employer_________________________________

Subscriber Name___________________________

Policy Number _____________DOB________

SS#______________________________________

MERGENCY or ALTERNATE CONTACT (In case we cannot reach you):

Name ______________________________ Relationship to Patient ___________ Phone No. _____________

FAMILY CONTACT INFORMATION:

Patient's Address _____________________ City _______________ Zip ______ Phone No. _____________

Lived There How Long? __________ Anticipate Moving? _____ When and Where? _____________________

Family Email address (for contact regarding appointments if necessary) ____________________________

How many brothers? _____________ Ages _____________ Sisters? _____________ Ages _____________

Do they have any orthodontic problems? ______________ Have they had any orthodontic treatment? ____________

Natural Parents? *Yes No*

Does father have normal teeth? _____________________ Father treated? ______________________________

Does mother have normal teeth? ____________________ Mother treated? ______________________________

Has anyone in the immediate family or extended family had jaw surgery along with orthodontic treatment? *Yes No*

Father's Name _________________ Height: _______

If address and phone are different please fill in below;

Address ________________________________

Home Phone Number ______________________

Occupation ____________Employer ____________

Business Phone _______________DOB_________

Mother's Name _________________ Height: _______

If address and phone are different please fill in below;

Address ________________________________

Home Phone Number ______________________

Occupation ____________Employer ____________

Business Phone _______________DOB_________

Who is legally responsible for the patient? __________________________ **Phone No.** ______________________

Signature ____ **Date** ___________________________

4602 Beckley Road, Battle Creek MI 49015 269-963-4118

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DENTAL HISTORY

For Patients Under 18 Years of Age

Patient's Last Name ____________________ First ____________________ Middle _________________

Patient's Dentist ____

Dentist's Address ______________________________________ Dentist's Phone Number ___________

1. Yes No dk/u Started teething very early or late?
2. Yes No dk/u Primary (baby) teeth removed that were not loose?
3. Yes No dk/u Permanent or "extra" (supernumerary) teeth removed?
4. Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
5. Yes No dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
6. Yes No dk/u Teeth sensitive to hot or cold; teeth throb or ache?
7. Yes No dk/u Jaw fractures, cysts, mouth infections?
8. Yes No dk/u "Dead teeth", root canals treated?
9. Yes No dk/u Bleeding gums, bad taste, mouth odor?
10. Yes No dk/u Periodontal "gum" problems?
11. Yes No dk/u Food impaction between teeth?
12. Yes No dk/u "Gum boils", frequent canker sores, cold sores?
13. Yes No dk/u Is child taking any forms of fluoride?
14. Yes No dk/u Thumb, finger, sucking habit? Until ____
15. Yes No dk/u Abnormal swallowing habit (tongue thrusting?)
16. Yes No dk/u History of speech problems? Stammer Lisp
17. Yes No dk/u Mouth breathing habit, snoring, difficult in breathing?
18. Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
19. Yes No dk/u Any pain in jaw or ringing in the ears?
20. Yes No dk/u Does the patient experience any pain or soreness in the muscles of the face or around the ears?
21. Yes No dk/u Difficulty encountered in chewing or jaw opening?
22. Yes No dk/u Aware of loose, broken, or missing restorations (fillings)?
23. Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
24. Yes No dk/u Concerned about spaced, crooked, protruding teeth?
25. Yes No dk/u Aware or concerned about under or over developed jaw?
26. Yes No dk/u Any relative with similar tooth or jaw relationships?
27. Yes No dk/u Has patient ever been advised to take antibiotics prior to dental care?
28. Yes No dk/u Any wisdom tooth problems?
29. Yes No dk/u Has patient had any serious trouble associated with any previous dental treatment?
30. Yes No dk/u Onset of puberty (approximate date)?_______
31. Yes No dk/u Has patient ever had a prior orthodontic examination or treatment?
32. Yes No dk/u Has patient recently been under another dentist's care?
    Specialist ___________________________________
    Other ______________________________________
33. Yes No dk/u Has patient ever had periodontal (gum) treatment?
34. Yes No dk/u Would patient object to wearing orthodontic appliances (Braces) should they be indicated?
35. Yes No dk/u Does patient brush his/her teeth conscientiously?

Date of most recent examination _______________

How often does patient brush? ___________ floss? ________

In your own words, what is the concern about how your teeth look /bite that you or your dentist have?

____
____
____
____
____
____
____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following directions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this dental status I will inform this practice.

____

Signature of parent or guardian Date

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MEDICAL HISTORY
For Patients Under 18 Years of Age

Patient's Last Name ___________________ First ___________________ Middle ________________

Patient's Physician ____

1. Yes No dk/u Are you in good health?
2. Yes No dk/u Has there been any change in your health in the last year?
3. Date of last physical exam ______________________
4. Yes No dk/u Are you now under medical care? If so, for what?
   ____
5. Yes No dk/u Have you ever had a serious illness or operation? If so, please explain ________________________
   ____
6. Do you have or have you ever had any of the following?
   - a. Yes No dk/u Rheumatic fever or rheumatic heart disease
   - b. Yes No dk/u Congenital heart disease or defect
   - c. Yes No dk/u Cardiovascular disease (heart trouble, heart murmur, heart attack, coronary insufficiency or occlusion, high blood pressure, arteriosclerosis, stroke)
   - d. Yes No dk/u Allergy or hay fever
   - e. Yes No dk/u Asthma
   - f. Yes No dk/u Hives or skin rash
   - g. Yes No dk/u Fainting spells
   - h. Yes No dk/u Diabetes
   - i. Yes No dk/u Hepatitis, jaundice, or liver disease
   - j. Yes No dk/u Inflammatory rheumatism (painfully swollen joints)
   - k. Yes No dk/u Arthritis
   - l. Yes No dk/u Stomach ulcers
   - m. Yes No dk/u Kidney trouble
   - n. Yes No dk/u Tuberculosis
   - o. Yes No dk/u Persistent cough or cough up blood
   - p. Yes No dk/u AIDS or HIV positive
   - q. Yes No dk/u Sexually transmitted disease
   - r. Yes No dk/u Epilepsy or seizure disorder
   - s. Yes No dk/u Artificial joint prosthesis
   - t. Yes No dk/u Substance abuse (alcoholism, drug addiction)
   - u. Yes No dk/u Tobacco use (cigarettes, dip, etc.
   - v. Yes No dk/u Bone metabolism problems or medications to treat bone metabolism problems (osteoporosis, etc.)
7. Yes No dk/u Do you have any chest pain with exercise?
8. Yes No dk/u Are you ever short of breath after mild exercise?
9. Yes No dk/u Do your ankles swell?
10. Yes No dk/u Do you get short of breath when you lie down, or do you require extra pillows to sleep?
11. Yes No dk/u Have you had abnormal bleeding associated with previous surgery?
12. Yes No dk/u Have you ever required a blood transfusion?
13. Yes No dk/u Do you have any blood disorders such as anemia, etc.?
14. Yes No dk/u Have you ever had surgery or x-ray treatment for a tumor, growth, or other condition?

5. Are you taking any of the following?
   - a. Yes No dk/u Antibiotics or sulfa drugs
   - b. Yes No dk/u Anticoagulants (blood thinners)
   - c. Yes No dk/u Medicine for high blood pressure
   - d. Yes No dk/u Cortisone or steroids
   - e. Yes No dk/u Tranquilizers
   - f. Yes No dk/u Aspirin or anti-inflammatory agent
   - g. Yes No dk/u Dilantin or other anti-convulsant
   - h. Yes No dk/u Insulin, Tolbutamide, Orinase, or similar drug
   - i. Yes No dk/u Digitalis or drugs for heart trouble
   - j. Yes No dk/u Nitroglycerin
   - k. Yes No dk/u Narcotic Analgesic
   - l. Yes No dk/u Birth Control "pill"
   - m. Yes No dk/u Alcohol, Antabuse
   - n. Yes No dk/u Recreational Drugs
   - o. Yes No dk/u Bisphosphonates (Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)
   - p. Yes No dk/u Other medications? ___________________
     ____
6. ALLERGIES
   - a. Yes No dk/u Local anesthetics (Novocaine, etc.)
   - b. Yes No dk/u Penicillin or other antibiotics
   - c. Yes No dk/u Aspirin or anti-inflammatory drugs
   - d. Yes No dk/u Barbiturates, sedatives, or sleeping pills
   - e. Yes No dk/u Narcotic analgesics
   - f. Any other?______________________________
     ____
7. Yes No dk/u Does the patient follow directions?
8. Yes No dk/u Does patient have learning disabilities or need extra help with instructions?
9. Yes No dk/u Is the patient sensitive, self conscious?
10. Yes No dk/u Is the patient pregnant?

If there are any changes later to this history records or medical status, I will inform this practice. I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

____

Signature of parent or guardian Date

Medical History Update or Changes: Date: Comments: Initials:

____
____
____
____