

ORTHODONTIC ACQUAINTANCE CARD

MICHAEL O. WILLIAMS, D.D.S., P.A.

DATE _____ 19 _____

DATE OF BIRTH _____

PATIENT'S NAME _____ AGE _____ SEX _____

RES. ADDRESS _____ ZIP _____ PHONE _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

FATHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

BUS. ADDRESS _____

MOTHER'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUS. TELEPHONE _____

BUS. ADDRESS _____

HOBBIES AND SPORTS _____ NICKNAME _____

RESPONSIBLE PARTY _____ INSURED BY _____

AGES OF CHILDREN AT HOME _____

PARENTS MARITAL STATUS _____ Single _____ Married _____ Divorced _____ Separated _____

MEDICAL HISTORY

- 1. ARE YOU IN GOOD HEALTH? _____ YES NO
- 2. AT PRESENT ARE YOU UNDER MEDICAL CARE? _____ YES NO
- 3. WHAT WAS THE PURPOSE OF THE VISIT TO YOUR PHYSICIAN? _____
- 4. HAVE YOU EVER HAD A SEVERE ILLNESS? _____ YES NO
- 5. CHECK THOSE ITEMS WHICH YOU NOW ARE OR HAVE EVER BEEN TREATED FOR:

A. ANEMIA YES NO

B. ARTHRITIS OR JOINT DISEASE YES NO

C. ASTHMA YES NO

D. BONE DISORDERS YES NO

E. CANCER YES NO

F. DIZZINESS YES NO

G. EPILEPSY YES NO

H. FAINTING YES NO

I. HEAD AND NECK PAIN YES NO

J. HEART DISEASE YES NO

K. KIDNEY INVOLVEMENT YES NO

L. LIVER DISEASE YES NO

M. NERVOUSNESS YES NO

N. PROLONGED BLEEDING YES NO

O. RESPIRATORY DISORDERS YES NO

P. RHEUMATIC FEVER YES NO

Q. TUBERCULOSIS YES NO

R. SEXUALLY TRANSMITTED DISEASE YES NO

S. HAVE YOU BEEN TESTED FOR AIDS YES NO

ENDOCRINE PROBLEMS

1. THYROID YES NO

2. DIABETES YES NO

3. OTHER _____

DRUG SENSITIVITIES

1. NOVOCAIN YES NO

2. PENICILLIN YES NO

3. ASPIRIN YES NO

4. CODEINE YES NO

5. OTHER _____

6. LIST ALL DRUGS OR MEDICATION NOW BEING TAKEN: _____

7. LIST ALLERGIES: _____

8. HAS ANYONE IN YOUR FAMILY HAD DIABETES? _____

9. WOMEN: ARE YOU PREGNANT? _____

10. HAS THE PATIENT REACHED PUBERTY? GIRLS—HAS SHE STARTED MENSTRUATING? BOYS—HAS HIS VOICE CHANGED
HEIGHT: _____ WEIGHT: _____

GROWTH RATE: SLOW _____ AVERAGE _____ FAST _____

RESEMBLES: MOTHER _____ FATHER _____ ADOPTED _____

DISPOSITION: OBEDIENT _____ COOPERATIVE _____ INDEPENDENT _____ REBELLIOUS _____

DOES PATIENT HAVE TENDENCY TO COLDS _____ SORE THROATS _____ EAR INFECTIONS _____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES NO WHAT AGE? _____

WAS YOUR CHILD BREAST FED FORMULA FED

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH DURING THE PAST 12 MONTHS? _____ YES NO

DO YOU HAVE ANY SPEECH PROBLEMS? _____ YES NO

DO YOU HAVE ANY EXTRA PERMANENT TEETH? _____ YES NO

HAS PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ YES NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ YES NO

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

ARE YOU MISSING ANY TEETH? _____ YES NO

HAVE YOU EVER HAD:

A. ORTHODONTIC TREATMENT? _____ YES NO

B. ORAL SURGERY? _____ YES NO

C. PERIODONTAL TREATMENT? _____ YES NO

D. YOUR TEETH GROUND OR THE BITE ADJUSTED? _____ YES NO

E. WORN BITE PLATE OR OTHER APPLIANCE? _____ YES NO

PROBLEMS OF THE JAW—HAVE YOU EVER EXPERIENCED:

A. CLICKING OF THE JAW? _____ YES NO

B. PAIN (JOINT, EAR, SIDE OF FACE)? _____ YES NO

C. DIFFICULTY IN OPENING AND CLOSING? _____ YES NO

D. DIFFICULTY IN CHEWING? _____ YES NO

HABITS—DO YOU:

A. BITE YOUR FINGERNAILS? _____ YES NO

B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? _____ YES NO

C. BITE YOUR LIPS OR CHEEKS REGULARLY? _____ YES NO

D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? _____ YES NO

E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? _____ YES NO

DO YOU HAVE HEADACHES? _____ YES NO

FREQUENCY _____

LOCATION _____

WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? _____

REASON FOR CONSULTATION: _____

DATE: _____ SIGNATURE: _____

OFFICE USE ONLY

RESUME

MEDICAL HISTOY _____

DENTAL HISTORY _____

ORDER OF IMPORTANCE TO THE PATIENT:

ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS
OCCLUSION PERIODONTICS PREPROSTHETICS
TMJ ORTHOGNATHIC OTHER

REFERRAL SOURCES:

GENERAL DENTIST ORTHODONTIST PERIODONTIST
ORAL SURGEON PLASTIC SURGEON FRIEND/RELATIVE
PHONE BK/SELF OTHER SHOPPERS