Brighter Smiles by
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ORTHODONTIC ACQUAINTENCE FORM

Patient's Name_____
Birth Date_____Age_____
Home Address_____
Phone_____Today's Date_____

Father's or Spouses Name_____Occupation_____Employed by_____
Business Address_____Phone_____
Mother's or Spouses Name_____Occupation_____Employed by_____
Business Address_____Phone_____
Patient's Physician_____Patient's Dentist_____
Person Financially Responsible_____Social Security Number_____
Person filling out this form_____
What would you like changed about your face, jaws, or teeth?_____
_____
If you need braces, what kind would you like?_____

Medical History (circle Yes or No and fill in blanks where required)

1. Is the patient in good health?----------Yes No
2. Have tonsils and/or adenoids been removed? At what age?_____----------Yes No
3. Frequent colds, sore throat, or ear infections?----------Yes No
4. Any history of major illness? If yes, list_____Yes No
5. Any allergies or drug sensitivities? If yes, list_____Yes No
6. Taking medication now? Reason_____Yes No
7. Under medical care now? Reason _____Yes No
8. Circle any of the following for which patient has been treated:

Hepatitis	Convulsions	Emotional problems	Fainting
Diabetes	Asthma	Prolonged bleeding	Tonsillitis
Arthritis	Epilepsy	Nervous disorders	Brain Injury
Heart Trouble	Rheumatic fever	Endocrine problems	Tuberculosis

9. Does the patient have any special problems not listed above?----------Yes No
   Explain_____

Dental History (circle answer)

1. Date of last dental exam_____Is work completed?----------Yes No
2. Have there been any injuries to the face, mouth, or teeth?----------Yes No
3. Does your jaw joint ever click, pop, hurt, or get stuck?----------Yes No
4. Has patient ever sucked thumb or fingers? Until what age?_____----------Yes No
5. Has patient ever had oral habits, such as lip biting or tongue thrusting?----------Yes No
6. Does patient have any speech problems?----------Yes No
7. Has patient ever had any speech therapy?----------Yes No
8. Is patient a mouth breather while asleep or awake?----------Yes No
9. Are you aware of any missing or extra permanent teeth?----------Yes No
10. Has an orthodontist been consulted previously?----------Yes No
11. Has anyone in the family had orthodontic treatment?----------Yes No
12. Would you consider the patient's diet high in sweets?----------Yes No
13. List any musical instruments played_____How long?_____

Patient Information

Date_____ Date of Birth_____

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Social Security #_____

If Patient is a minor, give parent's or guardian's name_____

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

Responsible Party Information

Name_____
Last First Middle

Address_____
Street City State Zip

How long at this address?_____ Home Phone_____Work Phone_____

Previous Address (if less than 3 years)_____
Street City State Zip

Social Security #_____ Birthdate_____Relationship to Patient_____

Employer_____ Occupation_____ # Yrs. Employed_____

Spouse's Name_____
Last First Middle

Spouse's Employer_____ # Yrs. Employed_____

Occupation_____ Social Security #_____ Work Phone_____

Insurance Information

Insured's Name_____ Birthdate_____ Social Security #_____

Insurance Co._____ Group #_____ Local #_____

Insurance Co. Address_____

Do you have dual coverage Yes____ No____ If yes:

Insured's Name_____ Birthdate_____ Social Security #_____

Insurance Co._____ Group #_____ Local #_____

Insurance Co. Address_____ Insured's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____ Phone_____

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor)_____

CONFIDENTIAL (for pre treatment evaluation)

Thank you for your cooperation in supplying information for both sides of this form. Erik H. Madsen DDS MS