

**GET ACQUAINTED QUESTIONNAIRE
FOR PATIENT'S 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 _____ Date of Birth _____ Age _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Email Address _____ Cell Phone _____
 Family Dentist _____ City _____ Phone _____ Last Visit: _____
 Family Physician _____ City _____ Phone _____
 School _____ Grade _____ Name patient likes to be called _____
 Sports, Hobbies, etc. _____ Musical instrument played _____
 Parents' Full Names _____ Siblings (names.ages) _____
 Parents: Married _____ Separated _____ Divorced _____ Widowed _____ Single _____
 Siblings having had orthodontic treatment: _____
 Major reason for seeking orthodontic treatment: _____
 How did you hear about our office? _____

DENTAL HISTORY

	NO	UNSURE	YES	
Has there been a thumb or finger habit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Have there been any injuries to the face, mouth or teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Are you aware of any missing or extra permanent teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Has the patient had any speech problems or therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Does the patient:				
• clench or grind his/her teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• brush his/her teeth conscientiously?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
Does the patient have:				
• a history of periodontal (gum) problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• a problem with frequent cold/canker sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any difficulty opening his/her mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any clicking or discomfort in jaw joints near ears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• headaches or neckaches regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• pain in the jaw joints while eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____
• any congenital abnormalities? (cleft palate, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	notes: _____

ATTITUDE TOWARD TREATMENT

Is the patient aware of spaced, crooked or protruding teeth?..... No.... Yes Concerned?..... No... Yes
 Do you feel that it is becoming..... Better..... Worse..... Staying the Same
 What would you most like to have orthodontic treatment accomplish? _____
 Would the patient object to wearing orthodontic appliances (braces) should they be indicated? No Yes
 Are you aware that some appointments will infringe upon school/work time?..... No..... Yes
 Has the patient had any previous orthodontic examinations?.... No.... Yes.. Doctor: _____ Date: _____
 Previous Orthodontic Treatment? _____ Describe: _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	_____	_____	_____	Hay Fever	_____	_____	_____
Allergies	_____	_____	_____	Healing Disorder	_____	_____	_____
Anemia or Bleeding Problems	_____	_____	_____	Headaches	_____	_____	_____
Arthritis	_____	_____	_____	Hearing Disorder	_____	_____	_____
Asthma	_____	_____	_____	Heart Disorders (murmur, etc.)	_____	_____	_____
Behavioral Problems	_____	_____	_____	Hepatitis or Liver Disorders	_____	_____	_____
Bone or Joint Disorder	_____	_____	_____	HIV Positive	_____	_____	_____
Breathing or Nasal Disorder	_____	_____	_____	Kidney or Bladder Condition	_____	_____	_____
Diabetes	_____	_____	_____	Mononucleosis	_____	_____	_____
Earaches	_____	_____	_____	Nervous Disorders	_____	_____	_____
Epilepsy or Convulsions	_____	_____	_____	Psychiatric Treatment	_____	_____	_____
Fainting or Dizziness	_____	_____	_____	Psychological Disorder	_____	_____	_____
Gagging or Nausea Problems	_____	_____	_____	Rheumatic Fever	_____	_____	_____
Growth or Endocrine Condition	_____	_____	_____				

General health: Good _____ Fair _____ Poor _____ Birth Defects _____

Presently under medical care for _____

Drugs or medication being taken now (drug and dose) _____

Allergic to any medication _____

Does the patient require antibiotic premedication prior to dental appointments?..... No.... Yes

Is the patient a mouth breather?..... No..... Yes..... While asleep..... While awake

Have tonsils and adenoids been removed?..... No..... Yes..... At what age? _____

Does the patient snore at night?..... No..... Yes

Growth in the past 6 months: _____

Has the patient reached puberty?..... No..... Yes

Height:..... Patient's _____ Mother's _____ Father's _____

RESPONSIBLE PARTY INFORMATION

Name _____

Residence _____

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs) _____ Zip _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Spouse's Address _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Name of nearest relative not living with you _____

Home Phone

Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

Do you have dual coverage? No Yes If Yes:

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____

Signature of parent or guardian _____ Date _____

I give permission for patient records to be used for research/educational purposes. _____ Initials

I give permission for pictures of my child to be used on our website or social network. _____ Initials