WHITBY ORTHODONTICS

ACQUAINTANCE FORM (CH/ADOL)

Patient's Name: _____ Date: _____

Date of Birth: ____ MM ____ DD ____ YY Age: _____ Sex: _____ Patient Resides With: Mother □ Father □

Home Address: _____ City: _____ Postal: _____

Patient's Dentist: _____ Physician: _____ Physician's Tel: _____

Who may we thank for referring you? _____

Mother's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Mother's Address: _____ Same as above □ City: _____ Postal: _____

Father's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Father's Address: _____ Same as above □ City: _____ Postal: _____

Person responsible for account: _____

Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure

MEDICAL HISTORY - HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Disease	□ Yes □ No	Sexually Transmitted Diseases	□ Yes □ No	Asthma	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Blood Pressure	□ Yes □ No	Arthritis	□ Yes □ No
Artificial Joints	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	Other _____	

If you responded YES to any of the above questions, please give pertinent information: _____

_____

Is the child in good health? _____ Have tonsils or adenoids been removed? □ Yes □ No At what age? _____

Does the child have a tendency to colds? □ Yes □ No Sore Throats? □ Yes □ No Ear Infections? □ Yes □ No

Are any drugs or medications now being taken? □ Yes □ No Please list and give reasons: _____

Does the child have any history of major illness and/or operations? _____

List any allergies or drug sensitivities (including sensitivity to metals): _____

Has the patient reached puberty? Girls-Has menstruation started? □ Yes □ No

Boys-Has voice changed yet? □ Yes □ No

DENTAL HISTORY

Has the child ever been treated for a jaw joint problem, including surgery?		□ Yes □ No	
Has the child ever experienced clicking, cracking or locking of the jaw joints?		□ Yes □ No	
Have there been any injuries to the face, mouth or teeth?		□ Yes □ No	Please describe: _____
Has the child ever sucked his/her thumb or finger?		□ Yes □ No	Until what age? _____
Does the child have any speech problems?		□ Yes □ No	
Does the child have frequent canker or cold sores?		□ Yes □ No	
Is the child a mouth breather?	While Asleep:	□ Yes □ No	While Awake: □ Yes □ No
Have you been informed of any missing or extra permanent teeth?		□ Yes □ No	
Has the child ever had a previous orthodontic examination?		□ Yes □ No	
Is the child especially apprehensive towards dental visits?		□ Yes □ No	
Does the child want orthodontic treatment?		□ Yes □ No	
Has any other family member had braces or orthodontic treatment?		□ Yes □ No	

Please name the family member if treated in our office: _____

When did the child last see the family dentist? _____

List any sports, hobbies or musical instruments played: _____

Reason for orthodontic consultation: _____

RELEASE OF INFORMATION: I hereby give Dr. Ronald L. Sperber, Dr. David Simone, and/or members of staff permission to release information concerning me or my child's dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information Includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Team member Dr. Ronald L. Sperber/Dr. David Simone