WHITBY ORTHODONTICS

ACQUAINTANCE FORM (CH/ADOL)

Patient's name: _____ Gender: _____

Date of Birth: ____ MM ____ DD ____ YY Age: _____ Patient resides with: _____

Home address: _____ City: _____ Postal: _____

Patient's dentist: _____ Physician: _____ Physician's tel: _____

Who may we thank for referring you? _____

Primary responsible party: Name: _____ Email: _____

Home tel: _____ Daytime tel: _____ □ Cell □ Work □ Home Relationship: _____

Address: □ Same as above _____ City: _____ Postal: _____

Other responsible party: Name: _____ Relationship: _____

Home tel: _____ Daytime tel: _____ □ Cell □ Work □ Home

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	Hypertension	□ 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? _____

Does the child have any allergies, drug sensitivities or sensitivity to metals? □ Yes □ No List: _____

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 Signature of Doctor