

ORTHODONTICS AQUAINTANCE CARD-CHILD

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ACCT.# _____

GENERAL INFORMATION

EXAM DATE _____

Patient's Name _____ Age _____ Birthdate _____ Sex _____

Legal Guardian(s) _____ Hm Phone _____

Mailing Address _____ Zip _____

Physical Address _____ Mr & Mrs. _ Mr. _____ Ms.

Legal Guardian is: Parents Mother Father Other _____

Who may we thank for referring you to our office? _____ Ortho Insurance Yes No

Father/Guardian Name _____ Employed by _____

Occupation _____ Bus. Phone _____ SS# _____

Mother/Guardian Name _____ Employed by _____

Occupation _____ Bus. Phone _____ SS# _____

Patient's Dentist _____ Physician _____ Oral Surgeon _____

Name and ages of children in family _____

Name and phone of close friend or relative not living with you _____

School _____ Grade _____

MEDICAL HISTORY

Is patient under the care of a physician? Yes No

Is patient in good health? Yes No

Is patient taking any medications? _____ Yes No

Is patient allergic or sensitive to any medications? _____ Yes No

Has patient had tonsils or adenoids removed? Yes No

Has patient been exposed to or tested positive to HIV? Yes No

Has patient had any of the following?

(Rheumatic fever, hepatitis, diabetes, asthma, tuberculosis, kidney or liver problems, endocrine condition, epilepsy, stomach ulcers, prolonged bleeding, bone disorder, heart disease, allergies, ADD, ADHD, other.) If so, please circle.

Has patient reached puberty? Girls- Has she started menstruation? Yes No Height _____

Boys- Has his voice changed? Yes No Weight _____

DENTAL HISTORY

Date of last dental visit. Month _____ Year _____

Has patient had any injury to face, mouth or teeth? Yes No

Does the patient grind or clinch their teeth? Yes No

Does patient have any of the following jaw joint symptoms? Yes No

(Pain, joint noise, frequent headaches, difficulty in opening.) If so, please circle.

Has patient ever sucked finger or thumb? Until what age _____ Yes No

Does patient have any speech problems? Yes No

Does patient breathe mostly through mouth? Yes No

Please list any musical instruments played by mouth _____

ORTHODONTIC HISTORY

Has either parent had orthodontic treatment? Yes No

Please list any family members that have been treated in our office _____

Has an orthodontist been consulted previously? Yes No

What motivated the patient to seek orthodontic care? _____

What concerns patient most about the thought of having braces? (Appearance, cost, how long, discomfort, will it work) Please circle.

Patient's favorite sports, hobbies, interests _____

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

I authorize your office to release and receive correspondence with our child's general dentist as pertinent to their treatment. initial _____

Parent or guardian's signature _____