Foster Orthodontics — *Practice Limited to Orthodontics*

Orthodontic (Child) Acquaintance Card

Date _____

Patient Information

Patient's Name_____ Preferred Name_____ Sex___ DOB_____

Home Address_____ City_____

State___ Zip_____ Home #/Cell_____ Age ____Grade _____School_____

Patients Dentist_____ Patients Physician_____

Fathers Name_____ DOB_____ Social Security #_____

Address _____ _____ Employer_____ cell/work #_____

Mothers Name_____ DOB_____ Social Security # _____

Address _____ _____ Employer_____ cell/work#_____

Person Responsible for Account_____ Social Security #_____ cell/work#_____

Address if diff. from patient_____

General Appraisal

Why did you make this appointment?_____

What is your concern about your child's teeth? Appearance_____ Function_____ Psychological _____Emotional _____Other_____

List names and ages of other children in the family_____

Have any members of your family received orthodontic treatment? _____Who _____When_____ Doctor_____

Has the patient ever been teased about the appearance of his/her teeth? Yes____ No____

Are you aware that some appointments will infringe on school time or work? Yes____ No____

Hobbies, Activities, Special interests_____

Medical History

Is patient in good health? Yes____No____Explain_____

Does patient have any history of major illness? Yes____No____Explain_____

Have tonsils and adenoids been removed? Yes___ No____ Age____ List any drug allergies_____

List any medications currently taking/give reason_____

GIRLS- has she started menstruation? Yes____ No____ If yes, when? _____ **BOYS**- Has voice changed? Yes____ No____

Dental History

Have there been any injuries to the face, mouth or teeth? Yes____ No____ Explain_____

Have you been informed of any missing or extra permanent teeth? Yes___ No___ Explain_____

Does patient have any speech problems? Yes___ No___ Has patient ever sucked a thumb or fingers? Yes ___ No___ until what age?_____

Is the patient a mouth breather? Yes___ No___ While awake? Yes ___ No___ While Asleep? Yes___ No___

Any noticeable difficulty in chewing or swallowing food? Yes___ No___ How long since last visit to dentist?_____

Do you have orthodontic insurance? Yes____ No____ _____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT