ACQUAINTANCE FORM Today's Date _____

Patient's Name _____ Nickname _____
Birthdate _____ Age _____ School _____ Grade _____
Patient's Brothers / Sisters and Ages _____
Patient's (under age 10) favorite pet, friend, or toy: _____
_____

Father or Guardian's Name _____ Soc. Sec. No. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Date of Birth _____
Place of Employment _____ Position _____ Years _____
Work Phone _____ Extension _____ E-mail _____

Mother or Guardian's Name _____ Soc. Sec. No. _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Date of Birth _____
Place of Employment _____ Position _____ Years _____
Work Phone _____ Extension _____ E-mail _____

If no telephone, please give a number for where we can leave a message:
Name _____ Phone _____ Relationship _____

Person responsible for financial obligation: _____
Insurance: Do you have Dental Insurance? _____ If Yes, does it Include Orthodontic Coverage? _____
Name of Insurance Company: _____ ID #:_____
Who referred you to our office? _____

MEDICAL HISTORY

Physician _____ Last Visit _____
Address _____ Phone _____
Is your child taking any medication now? YES / NO If so, what? _____
Has your child been hospitalized? YES /NO When? _____ Why? _____
_____
Does your child have any allergies? YES / NO If so, what? _____

Has your child had any unusual reactions to any of these drugs? (check all that apply)

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Tylenol
☐ Local Dental Anesthesia ☐ Other Antibiotics ☐ Nitrous Oxide ☐ Valium
☐ Chloral Hydrate ☐ Seconal ☐ Other _____
☐ None of the Above

Has your child ever had any of the following conditions? (check all that apply)

☐ Hepatitis ☐ Tuberculosis ☐ Convulsions ☐ Heart Trouble ☐ Epilepsy
☐ Hyperactivity ☐ Rheumatic Fever ☐ Pneumonia ☐ Fainting ☐ Liver Disease
☐ Arthritis ☐ Prolonged Bleeding ☐ Anemia ☐ Asthma ☐ Herpes
☐ HIV Positive (AIDS) ☐ Seasonal Allergies ☐ Other _____ ☐ None of the Above

Does your child have any psychological or emotional problems that you feel should be brought to our attention?

_____

Has your child ever had experiences with other health professionals which have been unpleasant? _____

_____

Any other information which you consider important: _____

_____

DENTAL HISTORY

1. Previous Dental Experience: (If 1st visit, please check ☐ and skip to Section 2.)
   A. Name of last dentist _____
   B. Date of last visit _____ Was Treatment completed? _____
   C. Was the experience pleasant? _____
   D. Were X-rays taken? _____ Date _____ Number Taken _____
   E. Has your child seen an orthodontist? _____
   F. Has anyone in your family had orthodontic treatment? _____
2. Current Oral Habits:
   A. Does your child receive fluoride in any of the following forms?
      ☐ Water ☐ Toothpaste ☐ Vitamin drops ☐ Tablets ☐ Rinses ☐ Other_____
   B. Brushing:
      1. Toothbrush: ☐ soft ☐ medium ☐ hard 2. Frequency per day: _____
      3. Do you assist your child? YES / NO 4. How often? _____
      5. Does your child floss? YES / NO 6. How often? _____
   C. Please list your child's snack foods: _____
   D. Has your child ever taken a bottle to bed? YES / NO Contents? _____
3. Current Oral Conditions:
   A. Does your child suck his/her thumb, fingers, or blankets? _____
   B. Has your child experienced any cold sores in or around his/her mouth? _____
   C. Does your child have any speech problems? _____
   D. Do you feel your child may have: (check all that apply)

      ☐ Cavities ☐ Gum disease ☐ Crooked teeth (malocclusion)
      ☐ Other_____

   E. Do you desire complete dental care for your child? _____
      If not, with what specific problems would you like us to help? _____

Form completed by _____

Relationship to Patient _____ Date _____