Cole Orthodontic Associates, P.C.

CHILD/ADOLESCENT ORTHODONTIC ACQUAINTANCE FORM

GENERAL INFORMATION				DAT				
	PATIENT'S NAME							
	RESIDENTIAL ADDRESS							
3.	HOME PHONE NUMBER	PAF	RENT/GUA	RDIAN'S DAYTI	ME PHONE			
4.	SCHOOLDENTIST'S NAME	REF	FERRED B	Y:				
5.	DENTIST'S NAME	OR/	AL SURGE	ON'S NAME				
	NAME OF ACCOMPANYING ADULT							
7.	FATHER'S NAMEADDRESS	OC(CUPATION					
8.	ADDRESS	HOI	ME #		CELL#			
	EMPLOYED BY							
	BUSINESS ADDRESS							
11.	MOTHER'S NAME	OC	CUPATION					
12.	ADDRESS	HOI	ME#		_CELL#			
	EMPLOYED BY							
	BUSINESS ADDRESS							
15.	STEP PARENT/OTHER PARENT							
16.	ADDRESS MADDRESS MADDRESSMADDRESS	TELE	EPHONE_					
17.	LEGAL GUARDIAN MA	ARITAL	STATUS: I	MARRIED \square DIV	ORCED SEF	ARATED 🗆 (OTHER□	
18.	ADDRESS AND PHONE NUMBER							
19.	ORTHODONTICS INS. CO.#1G	ROUP#	<u> </u>	POLIC	CY #/S.S.#			
	ORTHODONTICS INS CO. #2G	ROUP#	<u> </u>	POLIC	CY#/S.S.#			
19.	WHO ASSUMES FINANCIAL RESPONSIBILITY?							
20.	CREDIT REFERENCE:BANK			OTHER_				
	SS# OF RESPONSIBLE PARTY	OTHERBIRTHDATE						
	OCCUPATION	_YEARS	WITH CU	RRANT EMPLO	YER			
21.	WE WOULD LIKE TO SEND YOU A TEXT MESSAG	SE TO C	ONFIRM Y	OUR APPOINT	MENTS IS THIS	OK? YES		
	NAME AND AGES OF OTHER CHILDREN IN FAMIL							
	PATIENT INTERESTS							
	PATIENT INTERESTSCLOSEST RELATIVE OR FRIEND: NAME							
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HA	VE YOU EVER HAD OR DO YOU HAVE:			
58.	PERSISTENT COUGHYES □ NO □ 62. PROLONGED BLEEDING	YES [] N	10 🗆
59.	SKELETAL/BONE DISORDERSYES NO 63. EXCESSIVE URINATION OR THIRST	YES [] N	10 [
60.	HEPATITIS (LIVER DISEASE)YES □ NO □ 64. COMPLICATION FOLLOWING MEDICAL TX	ayes [] N	10 🗆
61.	CANCERYES NO 65. FREQUENT COLDS	YES □] N	10 🗆
ΗA	AVE THE PATIENT EVER HAD OR DOES HE OR SHE HAVE:			
66.	A NEED FOR ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL TREATMENT?	YES [] N	0 🗆
	A HABIT OF BREATHING THROUGH YOUR MOUTH? WHILE AWAKE? YES ☐ NO ☐ WHILE ASLEEP			о [
68.	HAVE THE PATIENT'S TONSILS/ADENOIDS BEEN REMOVED?	YES □] N	ю [
	DOES THE PATIENT HAVE ANY AIRBORNE ALLERGIES SUCH AS HAY FEVER?			
	DOES THE PATIENT HAVE ANY OTHER ALLERGIES OR DRUG SENSITIVITIES?YES NO			
71.	HAS THE PATIENT REACHED PUBERTY? GIRLS – HAS SHE STARTED MENSTRUATION?	YES └	ļИ	0 [
	BOYS – HAS HIS VOICE CHANGED?			
70	DATES FOR THE ABOVE DO YOU FEEL YOUR CHILD IS READY FOR ORTHODONTIC TREATMENT?		7 N	
72.	DO YOU FEEL YOUR CHILD IS READY FOR ORTHODONTIC TREATMENT?	YES L	או ב	Ю _
	NTAL HEALTH			
73.	REASON FOR TODAY'S VISIT:			
74.	WHEN WAS THE PATIENT'S LAST DENTAL VISIT?		1	
75.	HAS THE PATIENT EVER HAD ANY PROBLEM ASSOCIATED WITH PREVIOUS DENTAL TREATMENT?	YES L	Л И	0 L
	IF SO, EXPLAIN:			
	HOW OFTEN DOES THE PATIENT BRUSH HIS OR HER TEETH?			
	WHAT MOUTH RINSE (IF ANY) DOES THE PATIENT USE? MEDIUM ☐ HARD ☐ NYLON ☐	NATUD	۸۱ [
80.	HOW OFTEN DOES THE PATIENT FLOSS?			
	DO THE PATIENT'S GUMS BLEED WHILE BRUSHING? DO THE PATIENT'S GUMS BLEED WHILE FLOSSING?			10 [10 [
83.	DOES THE PATIENT FEEL TWINGES OF PAIN WHEN HIS/HER TEETH COME IN CONTACT WITH			10 L
	A. HOT FOODS OR LIQUIDS, I.E. SOUP, COFFEE, TEA, ETC. B. COLD FOODS OR LIQUIDS, I.E. ICE CREAM, COLD FRUIT, ETC.	1 E S L	и П	
	C. SWEETS, I.E. CANDY, FRUIT, SWEET DESSERTS, ETC?	YES F		
84.	IS THERE A HISTORY OF MOUTH OR LIP ULCERS?	YES [io E
	DOES THE PATIENT HAVE ANY MISSING OR EXTRA PERMANENT TEETH?			io 🗀
	DO THE PATIENT'S GUMS FEEL TENDER OR SWOLLEN?			10 E
	DOES THE PATIENT FEEL PAIN TO ANY OF HIS/HER TEETH WHEN BRUSHING OR FLOSSING?			ю [
88.	DOES THE PATIENT HAVE DIFFICULTY CHEWING?	YES 🗆] N	ю [
89.	DOES THE PATIENT CLENCH OR GRIND HIS/HER JAWS WHILE SLEEPING OR DURING THE DAY?	YES 🗆] N	10 E
	OTHER HABITS, I.E. NAIL BITING, PENCIL CHEWING, FINGER OR THUMB SUCKING HABIT, ETC			
	DOES THE PATIENT HAVE A PROBLEM WITH HEADACHES?			10 🗆
	HAS THE PATIENT EVER HAD CLICKING OR PAIN IN HIS OR HER JAW?			10 [
	DO THE PATIENT'S JAWS EVERY FEEL TIRED?			10 [
	DOES THE PATIENT USUALLY HAVE MANY CAVITIES?			10 🖺
	HAS THE PATIENT EVER LOST OR BROKEN FILLINGS?			10 [
	HAS THE PATIENT EVER CHIPPED ANY TEETH?			10 [
	HAS THE PATIENT EVER HAD ANY INJURIES TO THE HEAD, FACE, JAWS, MOUTH OR TEETH?			10 🖺
	DOES THE PATIENT GAG EASILY?			10 <u> </u>
	IS THERE A PROBLEM WITH TOOTH POSITION(S), JAW POSITION, OR BITE?IF SO, EXPLAIN:			10 [
	IS THE PATIENT FAMILIAR WITH THE TERM "PREVENTIVE DENTISTRY?			10 🗀
	DOES THE PATIENT FEEL SELF CONSCIOUS ABOUT HIS OR HER TEETH OR APPEARANCE?		_	10 🖺
	HAS THE PATIENT EVER CONSULTED AN ORTHODONTIST PREVIOUSLY?		_	ю 🗀
	HAS THE PATIENT EVER HAD ORTHODONTIC TREATMENT?			ю 🗀
	HAS EITHER PARENT EVER HAD ORTHODONTIC TREATMENT?		l N	10 <u></u>
05.	PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT:			