Cole Orthodontic Associates, P.C.

CHILD/ADOLESCENT ORTHODONTIC ACQUAINTANCE FORM

GENERAL INFORMATION

DATE _____ DATE OF BIRTH _____
AGE _____ SEX _____

1. PATIENT'S NAME _____ E-MAIL _____
2. RESIDENTIAL ADDRESS _____
3. HOME PHONE NUMBER _____ PARENT/GUARDIAN'S DAYTIME PHONE _____
4. SCHOOL _____ REFERRED BY: _____
5. DENTIST'S NAME _____ ORAL SURGEON'S NAME _____
6. NAME OF ACCOMPANYING ADULT _____ RELATIONSHIP TO PATIENT _____
7. FATHER'S NAME _____ OCCUPATION _____
8. ADDRESS _____ HOME # _____ CELL# _____
9. EMPLOYED BY _____ BUSINESS TELEPHONE _____
10. BUSINESS ADDRESS _____
11. MOTHER'S NAME _____ OCCUPATION _____
12. ADDRESS _____ HOME# _____ CELL# _____
13. EMPLOYED BY _____ BUSINESS TELEPHONE _____
14. BUSINESS ADDRESS _____
15. STEP PARENT/OTHER PARENT _____
16. ADDRESS _____ TELEPHONE _____
17. LEGAL GUARDIAN _____ MARITAL STATUS: MARRIED ☐ DIVORCED ☐ SEPARATED ☐ OTHER ☐
18. ADDRESS AND PHONE NUMBER _____
19. ORTHODONTICS INS. CO.#1 _____ GROUP # _____ POLICY #/S.S.# _____
    ORTHODONTICS INS CO. #2 _____ GROUP # _____ POLICY#/S.S.# _____
19. WHO ASSUMES FINANCIAL RESPONSIBILITY? _____
20. CREDIT REFERENCE:BANK _____ OTHER _____
    SS# OF RESPONSIBLE PARTY _____ YEARS AT PRESENT ADDRESS _____ BIRTHDATE _____
    OCCUPATION _____ YEARS WITH CURRANT EMPLOYER _____
21. WE WOULD LIKE TO SEND YOU A TEXT MESSAGE TO CONFIRM YOUR APPOINTMENTS IS THIS OK? YES ☐ NO ☐
22. NAME AND AGES OF OTHER CHILDREN IN FAMILY _____
23. PATIENT INTERESTS _____
24. CLOSEST RELATIVE OR FRIEND: NAME _____ PHONE NO. _____

MEDICAL HEALTH

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE GIVE DATES, TREATING DOCTOR, TREATMENT REQUIRED, AND CURRENT STATUS ON THE REVERSE SIDE (UNDER NO. 101) AND INDICATE THE NUMBER OF THE QUESTION YOU ARE ELABORATING UPON. ALSO PLEASE INDICATE WITH AN * ANY CONDITION WHICH SIBLINGS OR PARENTS POSSESS.

25. GENERAL HEALTH: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐
26. NAME AND ADDRESS OF PHYSICIAN _____
27. LAST COMPLETED PHYSICAL _____ HAS THE PATIENT EVER BEEN UNDER TREATMENT IN A HOSPITAL? _____
28. YES ☐ NO ☐ REASON: _____
29. IS THE PATIENT TAKING ANY MEDICATION NOW? YES ☐ NO ☐ NAME(S) AND PURPOSE(S) _____

HAS THE PATIENT EVER HAD OR DOES HE OR SHE HAVE:

30. MONONUCLEOSIS	YES ☐	NO ☐	44. MUSCLE PROBLEMS	YES ☐	NO ☐
31. HEART DISEASE	YES ☐	NO ☐	45. FREQUENT SORE THROAT	YES ☐	NO ☐
32. RHEUMATIC FEVER	YES ☐	NO ☐	46. FREQUENT EAR INFECTIONS	YES ☐	NO ☐
33. ABNORMAL BLOOD PRESSURE	YES ☐	NO ☐	47. FAINTING SPELLS	YES ☐	NO ☐
34. ULCERS	YES ☐	NO ☐	48. A BLOOD TRANSFUSION	YES ☐	NO ☐
35. TUBERCULOSIS	YES ☐	NO ☐	49. IMMUNE SYSTEM DISORDERS	YES ☐	NO ☐
36. DIABETES	YES ☐	NO ☐	50. EMOTIONAL/PSYCHOLOGICAL PROBLEMS.	YES ☐	NO ☐
37. EPILEPSY/CONVULSIONS	YES ☐	NO ☐	51. HEART MURMUR	YES ☐	NO ☐
38. CONGENITAL HEART LESIONS	YES ☐	NO ☐	52. JAUNDICE	YES ☐	NO ☐
39. STOMACH/INTESTINAL PROBLEMS	YES ☐	NO ☐	53. ASTHMA	YES ☐	NO ☐
40. GLAUCOMA	YES ☐	NO ☐	54. SINUS TROUBLE	YES ☐	NO ☐
41. ANEMIA	YES ☐	NO ☐	55. AIDS VIRUS OR ARC	YES ☐	NO ☐
42. CONTACT LENSES	YES ☐	NO ☐	56. NERVOUS SYSTEM DISORDERS	YES ☐	NO ☐
43. SKIN OR CONNECTIVE TISSUE DISEASE	YES ☐	NO ☐	57. ARTHRITIS	YES ☐	NO ☐

↓ CONTINUED ON BACK ↓

HAVE YOU EVER HAD OR DO YOU HAVE:

58. PERSISTENT COUGH..... YES ☐ NO ☐
59. SKELETAL/BONE DISORDERS..... YES ☐ NO ☐
60. HEPATITIS (LIVER DISEASE)..... YES ☐ NO ☐
61. CANCER..... YES ☐ NO ☐
62. PROLONGED BLEEDING..... YES ☐ NO ☐
63. EXCESSIVE URINATION OR THIRST..... YES ☐ NO ☐
64. COMPLICATION FOLLOWING MEDICAL TX.. YES ☐ NO ☐
65. FREQUENT COLDS..... YES ☐ NO ☐

HAVE THE PATIENT EVER HAD OR DOES HE OR SHE HAVE:

66. A NEED FOR ANTIBIOTIC PROPHYLAXIS BEFORE DENTAL TREATMENT?..... YES ☐ NO ☐
67. A HABIT OF BREATHING THROUGH YOUR MOUTH? WHILE AWAKE? YES ☐ NO ☐ WHILE ASLEEP? YES ☐ NO ☐
68. HAVE THE PATIENT'S TONSILS/ADENOIDS BEEN REMOVED?..... YES ☐ NO ☐
69. DOES THE PATIENT HAVE ANY AIRBORNE ALLERGIES SUCH AS HAY FEVER?..... YES ☐ NO ☐
70. DOES THE PATIENT HAVE ANY OTHER ALLERGIES OR DRUG SENSITIVITIES?..... YES ☐ NO ☐ _____
71. HAS THE PATIENT REACHED PUBERTY? GIRLS – HAS SHE STARTED MENSTRUATION?..... YES ☐ NO ☐
BOYS – HAS HIS VOICE CHANGED?..... YES ☐ NO ☐
DATES FOR THE ABOVE _____
72. DO YOU FEEL YOUR CHILD IS READY FOR ORTHODONTIC TREATMENT?..... YES ☐ NO ☐

DENTAL HEALTH

73. REASON FOR TODAY'S VISIT: _____
74. WHEN WAS THE PATIENT'S LAST DENTAL VISIT? _____
75. HAS THE PATIENT EVER HAD ANY PROBLEM ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES ☐ NO ☐
76. IF SO, EXPLAIN: _____
77 HOW OFTEN DOES THE PATIENT BRUSH HIS OR HER TEETH? _____
78. WHAT MOUTH RINSE (IF ANY) DOES THE PATIENT USE? _____
79. WHAT TEXTURE BRUSH DOES THE PATIENT USE? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐
80. HOW OFTEN DOES THE PATIENT FLOSS? _____
81. DO THE PATIENT'S GUMS BLEED WHILE BRUSHING?..... YES ☐ NO ☐
82. DO THE PATIENT'S GUMS BLEED WHILE FLOSSING?..... YES ☐ NO ☐
83. DOES THE PATIENT FEEL TWINGES OF PAIN WHEN HIS/HER TEETH COME IN CONTACT WITH
A. HOT FOODS OR LIQUIDS, I.E. SOUP, COFFEE, TEA, ETC. ..... YES ☐ NO ☐
B. COLD FOODS OR LIQUIDS, I.E. ICE CREAM, COLD FRUIT, ETC. ..... YES ☐ NO ☐
C. SWEETS, I.E. CANDY, FRUIT, SWEET DESSERTS, ETC?..... YES ☐ NO ☐
84. IS THERE A HISTORY OF MOUTH OR LIP ULCERS? ..... YES ☐ NO ☐
85. DOES THE PATIENT HAVE ANY MISSING OR EXTRA PERMANENT TEETH?..... YES ☐ NO ☐
86. DO THE PATIENT'S GUMS FEEL TENDER OR SWOLLEN? ..... YES ☐ NO ☐
87. DOES THE PATIENT FEEL PAIN TO ANY OF HIS/HER TEETH WHEN BRUSHING OR FLOSSING?..... YES ☐ NO ☐
88. DOES THE PATIENT HAVE DIFFICULTY CHEWING?..... YES ☐ NO ☐
89. DOES THE PATIENT CLENCH OR GRIND HIS/HER JAWS WHILE SLEEPING OR DURING THE DAY?..... YES ☐ NO ☐
90. OTHER HABITS, I.E. NAIL BITING, PENCIL CHEWING, FINGER OR THUMB SUCKING HABIT, ETC.. _____
91. DOES THE PATIENT HAVE A PROBLEM WITH HEADACHES?..... YES ☐ NO ☐
92. HAS THE PATIENT EVER HAD CLICKING OR PAIN IN HIS OR HER JAW?..... YES ☐ NO ☐
93. DO THE PATIENT'S JAWS EVERY FEEL TIRED? ..... YES ☐ NO ☐
94. DOES THE PATIENT USUALLY HAVE MANY CAVITIES? ..... YES ☐ NO ☐
95. HAS THE PATIENT EVER LOST OR BROKEN FILLINGS?..... YES ☐ NO ☐
96. HAS THE PATIENT EVER CHIPPED ANY TEETH? ..... YES ☐ NO ☐
97. HAS THE PATIENT EVER HAD ANY INJURIES TO THE HEAD, FACE, JAWS, MOUTH OR TEETH? ..... YES ☐ NO ☐
98. DOES THE PATIENT GAG EASILY?..... YES ☐ NO ☐
99. IS THERE A PROBLEM WITH TOOTH POSITION(S), JAW POSITION, OR BITE?..... YES ☐ NO ☐
IF SO, EXPLAIN: _____
100. IS THE PATIENT FAMILIAR WITH THE TERM "PREVENTIVE DENTISTRY?..... YES ☐ NO ☐
101. DOES THE PATIENT FEEL SELF CONSCIOUS ABOUT HIS OR HER TEETH OR APPEARANCE? ..... YES ☐ NO ☐
102. HAS THE PATIENT EVER CONSULTED AN ORTHODONTIST PREVIOUSLY?..... YES ☐ NO ☐
103. HAS THE PATIENT EVER HAD ORTHODONTIC TREATMENT?..... YES ☐ NO ☐
104. HAS EITHER PARENT EVER HAD ORTHODONTIC TREATMENT?..... YES ☐ NO ☐
105. PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT: _____

_____

PARENT'S SIGNATURE DATE