ORTHODONTIC ACQUAINTANCE FORM
JETSON S. LEE, D.D.S., M.S.D.

PATIENT'S NAME _____ Nickname _____ Date _____
First Middle Last

Date of Birth _____ Age _____ Sex _____ Whom may we thank for referring you? _____

School _____ Grade _____ Hobbies _____

We request this information so we can communicate properly with the people involved with your child's treatment.

With whom does the patient live? _____ ❑ Parent ❑ Guardian ❑ Other _____

Are the parents separated? ❑ Yes ❑ No Divorced? ❑ Yes ❑ No Remarried? ❑ Yes ❑ No

Responsible Party Information

Name _____ Relationship to patient _____
First Middle Last

Address

_____
Street City State Zip Code

Home Phone # _____ Social Security # _____ Driver's License # _____

Employer _____ Occupation _____ Work Phone # _____

Spouse's Name _____ Relationship to patient _____
First Middle Last

Social Security # _____ Driver's License # _____

Employer _____ Occupation _____ Work Phone # _____

Dental Insurance Information

Insured's Name _____ Relationship to patient _____
First Middle Last

Insured's Social Security # _____ Insured's Date of Birth _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone #

_____

Insured's Employer _____ Employer's Address

_____

Do you have dual coverage? ❑ Yes ❑ No If yes:

Insured's Name _____ Relationship to patient _____
First Middle Last

Insured's Social Security # _____ Insured's Date of Birth _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Phone #

_____

Insured's Employer _____ Employer's Address _____

Emergency Information

Name of nearest friend or relative **NOT** living with you _____

Address _____ Phone # _____

(Please continue on back)

Medical History

Physician's Name _____ Last Medical Exam _____ Medical Card # _____

Address _____ Phone # _____

Is patient taking any medications now, what? _____ For what purpose? _____

Is the patient allergic to: ❑ Penicillin ❑ Codeine ❑ Local anesthetic injections ❑ Other

Is the patient's general health good? ❑ Yes ❑ No Reason _____

Any major or unusual illnesses? ❑ Yes ❑ No Reason _____

Is the patient being treated by a physician now? ❑ Yes ❑ No For What? _____

Has the patient ever been diagnosed or treated for any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Heart disease	❑	❑	Hepatitis or liver problems	❑	❑	A.I.D.S.
❑	❑	Congenital heart defect	❑	❑	Jaundice	❑	❑	H.I.V. positive
❑	❑	Rheumatic fever	❑	❑	Stomach problems /ulcers	❑	❑	Venereal disease
❑	❑	Heart murmur	❑	❑	Diabetes	❑	❑	Herpes
❑	❑	Bleeding problems	❑	❑	Epilepsy	❑	❑	Asthma/breathing problems
❑	❑	Anemia	❑	❑	Cancer or leukemia	❑	❑	Tuberculosis or lung disease
❑	❑	Abnormal blood pressure	❑	❑	Frequent headaches	❑	❑	Sinus trouble or hay fever

If yes, please explain

_____

Does the patient have or have had any other diseases or medical problems **NOT** listed on this form? ❑ Yes ❑ No

If so, please explain:

_____

Female patients only: Has patient started a menstrual cycle? ❑ Yes ❑ No When? _____

Dental History

Reason for this visit? _____ General Dentist _____

Date of last visit _____ Last X-rays _____ Is the patient having any dental pain at this time? _____

Has the patient had or do you notice any of the following?

Yes	No		Yes	No	
❑	❑	Teeth sensitive to hot, cold, sweets or pressure	❑	❑	Clenching or grinding of teeth ❑ day ❑ night
❑	❑	Traumatic injury to teeth, mouth , or face	❑	❑	Loosening of your teeth
❑	❑	Pain or tenderness around ear, joint, or side of face	❑	❑	Periodontal treatment
❑	❑	Difficulty in: ❑ Opening ❑ Closing ❑ Chewing	❑	❑	Mouth breathing
❑	❑	Clicking, locking, or popping of jaw joint	❑	❑	Missing teeth
❑	❑	Tonsils or adenoids removed	❑	❑	Additional teeth
❑	❑	Oral habits: ❑ Thumb sucking ❑ Fingernail biting ❑ Cheek biting			
❑	❑	Pain and/or swelling of gums, bleeding of gums when brushing			

If yes, explain

_____

What do you feel is wrong with the patient's teeth or bite? _____

Has the patient had orthodontic treatment? ❑ Yes ❑ No When? _____ Orthodontic consultations? ❑ Yes ❑ No When? ____

Has any member of the family had orthodontic treatment? ❑ Yes ❑ No Who ? _____

Names and ages of patient's siblings _____

Patient's Height _____ Patient's Weight _____ Father's Height _____ Mother's Height _____

The patient's teeth most resemble? ❑ Mother ❑ Father Adopted? ❑ Yes ❑ No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I read and understand English.

Signature of parent or guardian _____ Date _____