

Wardlaw Orthodontics Patient Acquaintance Form

Nick Name _____ Sex _____ School _____ Grade _____

Name and ages of other children in family _____

MEDICAL HISTORY

Is patient in good health? _____ Yes _____ No Pregnant? _____ Yes _____ No

Please check box if patient has or has had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Prolonged bleeding problems |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Faintness / Dizziness | <input type="checkbox"/> Hepatitis or liver problems |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Bone disorders |
| <input type="checkbox"/> Congenital heart lesion | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Endocrine problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> HIV Virus (AIDS) | <input type="checkbox"/> Asthma or hay fever (circle) |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Emotional problems |
| <input type="checkbox"/> Anemia or hemophilia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Tonsils or adenoid problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis or joint swelling | <input type="checkbox"/> Tonsils or adenoid removed (circle) |
| | | <input type="checkbox"/> When _____ |

Name of Physician _____

Is patient under physician's care presently? _____ Yes _____ No Reason _____

List any other serious illnesses or major operations: _____

List any allergies or medications now being taken and reasons _____

Does Patient need premedication prior to dental work? _____ Yes _____ No

Explain _____

Does patient have tendency to colds? _____ Sore throats? _____ Ear infections? _____

Has patient reached puberty? _____ Males - voice changed? _____ Yes _____ No

Females - started menstruation? _____ Yes _____ No

Describe patient's temperament _____

Patient will probably be _____ eager to cooperate _____ cooperative _____ unwilling

but will go along _____ uncooperative

DENTAL HISTORY

Please check if answer is YES:

- ☐ Any injuries to face, mouth, teeth? (circle)
- ☐ Parts of mouth sensitive to temperature, pressure, food or drink?
- ☐ Frequent canker (cold) sores?
- ☐ Any extra or missing permanent teeth? (circle)
- ☐ Any teeth removed by extractions?
- ☐ Bleeding or swollen gums?
- ☐ Growths, swellings or sores in mouth?
- ☐ Any speech, or hearing problems? (circle)
- ☐ Mouth breathing when asleep, awake? (circle)
- ☐ Thumb, finger, lip sucking? (circle)
- ☐ Any pain or clicking on opening mouth? (circle)
- ☐ Difficulty in opening mouth widely?
- ☐ Jaw ever locked?
- ☐ Grinding or clenching of teeth?
- ☐ Musical instruments played?
- ☐ Headaches frequently?

I authorize the following individuals to act as appointed healthcare representatives with whom my child's health information may be discussed:

I have received and/or reviewed a copy of Wardlaw Orthodontics, P.A.'s Notice of Privacy Practices. (You may refuse to sign this acknowledgment.)

Guarantor Signature: _____

Date: _____

For Office Use Only: We could not obtain written acknowledgment of receipt of our Notice of Privacy Practices because:

Staff Signature: _____

Date: _____

Name of Dentist _____

Does patient visit dentist regularly? _____ Date of last dental visit _____

Has an orthodontist been consulted previously or has patient had previous orthodontic treatment? _____

Reason _____

Name of orthodontist _____

What is the patient's (or parents') primary concern (why are you here)? _____

Whom may we thank for referring you _____

SIGNATURE (Parent's signature if minor) _____

Date _____