ORTHODONTIC ACQUAINTANCE CARD

PATIENT NAME ______________________ DATE ____________ 20 ______

STREET ADDRESS ______________________ DATE OF BIRTH ______________

CITY ______________ ZIP ____________ AGE ______ SEX ________

TELEPHONE ______________

SCHOOL ______________ GRADE ______ REFERRED BY ______________

PATIENT'S DENTIST ______________ PHYSICIAN ______________

FATHER'S NAME ______________ OCCUPATION ______________

SOC. SEC. NO. ______________

EMPLOYED BY ______________ BUS. TEL. NO. ______________

MOTHER'S NAME ______________ OCCUPATION ______________

SOC. SEC. NO. ______________

EMPLOYED BY ______________ BUS. TEL. NO. ______________

BEST TELEPHONE NUMBER TO CALL FOR APPOINTMENT CONFIRMATION ______________

BEST TIME TO CALL FOR APPOINTMENT CONFIRMATION ______________

IS PATIENT IN GOOD HEALTH? ______________ YES ❑ NO ❑

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? ______ YES ❑ NO ❑

IF SO, PLEASE DESCRIBE ______________

____

____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN ______________

____

LIST ANY DRUG ALLERGIES OR SENSITIVITY ______________

____

HAVE TONSILS OR ADENOIDS BEEN REMOVED? IS SO, WHEN? ______________

HAS PATIENT REACHED ADOLESCENT GROWTH? ______________ YES ❑ NO ❑

GIRLS - HAS MONTHLY CYCLE STARTED? WHEN? ________ **BOYS**- HAS VOICE CHANGED? ________ WHEN? ______

PATIENT'S PRESENT HEIGHT ______ FT ______ IN

FATHER'S HEIGHT FT. ______ FT ______ IN

MOTHER'S HEIGHT ______ FT ______ IN

EXPECTED HEIGHT OF PATIENT ______ FT ______ IN

NAMES AND AGES OF BROTHERS AND/OR SISTERS ______________

____

____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? YES ❑ NO ❑

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? YES ❑ NO ❑ HOW LONG? ________

DOES PATIENT NORMALLY BREATHE THROUGH MOUTH OR NOSE? WHILE AWAKE MOUTH ❑ NOSE ❑

WHILE ASLEEP MOUTH ❑ NOSE ❑

ARE THERE ANY MISSING OR EXTRA TEETH? YES ❑ NO ❑

HAS THE PATIENT EVER SEEN AN ORTHODONTIST BEFORE? YES ❑ NO ❑

HAS MOTHER, FATHER, BROTHER OR SISTER EVER HAD ANY ORTHODONTIC TREATMENT? YES ❑ NO ❑

PRIMARY REASON FOR CONSULTATION ______________

____

____

ALL RECORDS TAKEN AT THIS OFFICE ARE THE SOLE PROPERTY OF DR. THEODORE D. FREELAND.
THERE IS A CHARGE TO DUPLICATE OUR RECORDS AND ALSO A RELEASE FORM MUST BE SIGNED.

DO YOU HAVE ORTHODONTIC DENTAL INSURANCE? YES ❑ NO ❑

NAME OF INSURANCE: ______________

NAME OF EMPLOYEE: ______________

GROUP # ______________

CONTRACT# ______________

EMPLOYEE SOC. SECURITY# ______________

PARENTS BIRTHDATE: Father ______________

Mother ______________

I understand that I am responsible for any fees incurred at this office.

____

PARENT OR GUARDIAN

Drivers License No.:

____

HISTORY

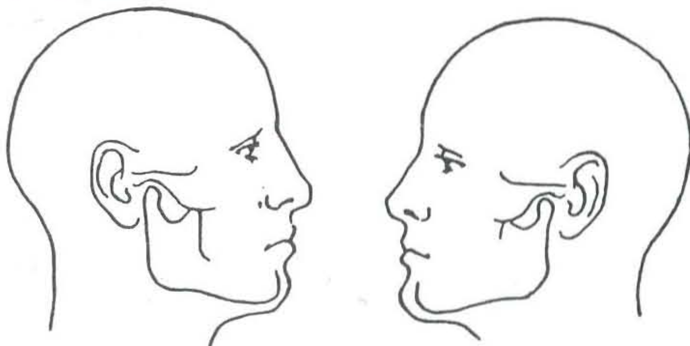
1. Describe your problem:____

____

2. Which side hurts? Right____________ Left____________ Both____________
3. For how long ?____

____

4. Is the pain constant or intermittent?______________________________
5. Is the pain worse in morning, afternoon,evening?______________________
6. Does it hurt to move your jaw____________? To chew____________?
7. On the figures below please outline where your pain is.
8. Does your jaw make noise?
   Clicking ____________________
   Grinding____________________
   When?____________________
   For how long?________________
   Other.____________________
9. Has your jaw ever locked...
   Open____________________
   Closed____________________
   When____________________
   How often?________________



10. If your jaw does not make noise or lock now, has it ever in the past?

____

____

11. Do you have?

a. Headaches	________	d. Ear pain	________
b. Neckaches	________	e. Ringing in the ears	________
c. Shoulder pain	________	f. Dizziness	________
		g. Change in hearing	________

12. Do you grind or clench your teeth?______________________________
    At night?____________________ During the day?____________________
13. Do you have sore or sensitive teeth?________________
14. Do you have trouble getting to sleep?________________
    Do you sleep well?________________
15. Do you consider yourself to be under a lot of stress? ____________________
    Are you nervous or anxious about anything?____________________
16. Have you ever had a nervous stomach, ulcers, skin disease?________________
17. Do you have or have you ever had arthritis?____________________
18. Does your pain keep you from doing anything? ____________________
    If yes, What?____

____

19. Can you remember any injury to your jaw?____________________
    If yes, describe:____

____

20. Do you take medications for the pain?____________________
    If yes, What?____
21. Do you take medications for relaxation?____________________
    If yes, what? ____
22. Have you had any treatments for your problem? ____________________
    If yes, what kind ?____

a. Bite splint	________	e. Occlusal adjustment	________
b. Medication	________	f. Orthodontics	________
c. Physical therapy	________	g. Surgery	________
d. Counseling	________	h. Other________________	