nu smile ORTHODONTICS

ORTHODONTIC ACQUAINTANCE CARD
CHILD

TODAY'S DATE: _____/_____/_____
DAY MONTH YEAR

Patient Name (Last): _____(First): _____ Date of Birth (D/M/Y) _____

Address: _____City: _____Postal Code: _____

Name of School: _____ □ Full time □ Part time

Phone(s): _____ E-mail:_____

Mother's Name: _____ Father's name: _____

Mother's E-mail: _____ Father's E-mail: _____

Mother's employer: _____ Father's employer: _____

Parent's marital status: □ Married □ Single □ Separated □ Divorced □ Widowed

Mother's date of birth (D/M/Y) _____ Father's date of birth (D/M/Y) _____

Mother's dental insurance name: _____ Father's dental insurance name: _____

Policy #: _____ID #: _____ Policy #: _____ID #: _____

Who is financially responsible for this child? □ Mother □ Father □ Other _____

Dentist: _____ Physician: _____

Who may we thank for referring you to our office: □ Dentist □ Family/Friend □ Patient □ Google □ Facebook □ Other

Details: _____ _____

Reason for seeking an orthodontic exam/tell us what you do not like about your child's teeth or bite:

_____

MEDICAL HISTORY

Please indicate if your child has ever been treated for:

□ Arthritis	□ Hormone problem	□ Tonsil/adenoids	□ Skin problems
□ Heart murmur	□ Diabetes	□Sleep apnea/snoring	□ Cold sores
□ Heart disease	□ Tuberculosis	□ Seizures	□ Osteoporosis
□ Clenching/grinding	□ Cancer	□ Asthma	□ Growth problems
□ Anemia	□ Hepatitis	□ Cleft lip/palate	□ Immune disorders

Details: _____

Does your child have any health problems?	□ Yes	□ No	If yes, Explain: _____
Does your child have any history of major illness?	□ Yes	□ No	If yes, Explain: _____
Is your child taking any drugs or medication?	□ Yes	□ No	If yes, Explain: _____
Does your child have any allergies?	□ Yes	□ No	If yes, Explain: _____

DENTAL HISTORY

Has your child had any serious head or face injuries?	□ Yes	□ No	If yes, Explain: _____
Has your child ever sucked a thumb or finger?	□ Yes	□ No	If yes, Explain: _____
Is your child a mouth breather?	□ Yes	□ No	If yes, Explain: _____
Does your child play any contact sports?	□ Yes	□ No	If yes, Which Ones: _____
Does your child play any musical (wind) instruments?	□ Yes	□ No	If yes, Which Ones: _____
Was your child's last dental check-up within 6 months?	□ Yes	□ No	If no, Explain: _____
Has your child had an orthodontic consultation before?	□ Yes	□ No	If yes, When/Who? _____
Has your child had previous orthodontic treatment?	□ Yes	□ No	If yes, When/Who? _____
Is your child having a growth spurt?	□ Yes	□ No	If yes, Explain: _____
Have any brothers/sisters had orthodontic treatment?	□ Yes	□ No	If yes, Explain: _____
Females: Has your child had her first period?	□ Yes	□ No	If yes, When? _____
Males: Has your child's voice changed?	□ Yes	□ No	If yes, When? _____