"CHILD-TEEN"
ACQUAINTANCE CARD
DARSEY-KRIVAN ORTHODONTICS

PLEASE COMPLETE DATE_____

Patient's Full Name_____ Likes to be called_____
Sex____ Age___Birth Date_____Family Dentist_____
Home address_____City _____
Zip_____ Hm.Phone (____)_____Cell Ph# (_____)_____
Other Phone # (_____)_____ Email _____
School presently attending_____Grade_____
Patient's hobby or special interests_____
Who brought the need for orthodontics to your attention?_____
Who told you about our office?_____Do you have orthodontic insurance?_____
Children in family:name:(age)_____(___)_____(___)
Father's Name_____Employed by_____Phone (____)_____
Mother's Name_____Employed by_____Phone (____)_____
Person responsible for account_____Ph# (_____)_____
Address_____City_____State _____Zip_____

DENTAL / MEDICAL HISTORY

Any previous orthodontic treatment?..... yes__no__
Please explain_____
Is there a history of any injuries to the face, mouth, jaws or teeth?..... yes__no__
Please explain_____
Is there a history of any finger or thumb habits?.....(Until what age?)_____..... yes__no__
Is there a tendency for mouth breathing or snoring ? ..... yes__no__
History of clenching or grinding teeth during day or night?..... yes__no__
Any history of popping, catching, locking or noise in jaw joint?..... yes__no__
Are frequent headaches a problem?..... yes__no__
What is your main reason for seeking orthodontic treatment? _____
_____
Is patient in good health?..... yes__no__
Have tonsils and/or adenoids been removed?..... yes__no__
Is there a history of rheumatic fever?..... yes__no__
Is there a history of any allergies or drug sensitivities?..... yes__no__
Please list_____
Are you allergic to rubber (latex) or metals(nickel)?..... yes__no__
History of testing HIV positive ?..... yes__no__
History of testing positive for Tuberculosis?..... yes__no__
Has the patient started her monthly periods? (When?_____)..... yes__no__
History of any major condition or illness such as hepatitis, diabetes, epilepsy, heart trouble, hormone or bleeding disorder or others?..... yes__no__
Please explain _____
_____
_____
Please list any medications patient is presently taking:_____
_____

Completed by:_____
(YOUR SIGNATURE, PLEASE)