



CHILD ORTHODONTIC ACQUAINTANCE FORM

Name _____ Date of Birth _____ Age: _____ Sex (check one): M ___ F ___
 Name Patient prefers to be called _____ Telephone: (____) _____ Cell : (____) _____

**Please check here if you would like to receive a text to remind you of your appointments.

Number of Years at Current Address: _____ Own or Rent: _____

School: _____ Grade: _____

Hobbies and Interests: _____ How did you hear about our office? _____

Father's Name: _____

Mother's Name: _____

Employed By: _____

Employed By: _____

Present Position: _____

Present Position: _____

City: _____ State: _____

City: _____ State: _____

Phone: (____) _____

Phone: (____) _____

Parent's Marital Status (check one): Married ___ Single ___ Divorced ___

Person Responsible for Account: _____

Responsible Party's Email: _____

Names of Other Children in Family:

_____ Date of Birth _____
 _____ Date of Birth _____
 _____ Date of Birth _____
 _____ Date of Birth _____

Other Family Members Treated in Our Office:

Orthodontic Insurance: Yes ___ No ___

If yes, Name of Carrier: _____

Name of Insured: _____

Employer of Insured: _____

Social Security Number of Insured: _____

Date of Birth of Insured: _____

MEDICAL AND DENTAL HISTORY

Name of your general dentist: _____ Date of last dental exam/cleaning: _____

Has an orthodontist been consulted previously? _____ When? _____

Patient's Physician: _____ Phone: (____) _____

Is the patient under the care of a physician for a specific problem? Yes ___ No ___

If yes, list problem(s): _____

List any medicines your child is taking: _____

List any drug sensitivities/allergies: _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY:

- | | | | |
|---|--------------------------|-------------------------|------------------------------|
| ____ Pre-medication (antibiotics) | ____ AIDS | ____ Hearing disorder | ____ Hepatitis/Liver Disease |
| for any medical/dental procedures | ____ Diabetes | ____ Nervous problems | ____ Ear Infections |
| ____ Head or facial injury | ____ Allergies or Asthma | ____ Emotional problems | ____ Arthritis |
| ____ Rheumatic Fever | ____ Bleeding problems | ____ Adopted | ____ Endocrine problems |
| ____ Kidney Disease | ____ Tonsillitis | ____ Tuberculosis | |
| ____ Epilepsy | ____ High blood pressure | ____ Heart Trouble | |
| ____ None of the above are medical issues for the patient | | | |

What part of your child's orthodontic problem concerns you most? _____

By signing below, I am certifying that all the above information I have entered is correct. I also understand that, where appropriate, credit reports may be obtained (note: credit reports obtained from Howell Orthodontics or any other health care provider have no affect on credit scores and will not appear on credit reports).

Signature: _____ Date: _____

(Parent or Legal Guardian)