WESTWALK ORTHODONTIC GROUP, P.C.

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APPT:
Dr. _____
Date _____
Time

ORTHODONTIC ACQUAINTANCE FORM

Acct. # **Case #** *this box for office use only*

Patient Name:_____ **Title**____ **Nickname**_____
first *m.i.* *last*
Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone No._____ **Email:**_____
area code *home* *cell* *cell phone carrier*
Birth Date:_____ **Age:**_____ **Sex:**____ **School:**_____

Dentist:_____ **Physician:**_____ **Who may we thank for referring you:**_____

Father's Social Sec. #_____ **Mother's Social Sec. #**_____

Name and Age of Other Children:_____

Mother's:

Name:_____
first *last*
Address:_____
if different than patient
City:_____ **State**____ **Zip Code**_____

Occupation:_____

Employer:_____

Address:_____
employers
City:_____ **State**_____

Phone #_____
employers phone # *extension*

Cell Phone:_____ **Cell Carrier**_____
Mother's

Father's:

Name:_____
first *last*
Address:_____
if different than patient
City_____ **State**_____ **Zip Code**_____

Occupation:_____

Employer:_____

Address:_____
employers
City:_____ **State**_____

Phone #_____
employers phone # *extension*

Cell Phone:_____ **Cell Carrier**_____
Father's

Marital Status of Parents: Married☐ **Seperated**☐ **Divorced**☐

Person Responsible for Payment:_____ **Address:**_____
if different from patient

Relationship of Responsible person to patient:_____ **Soc. Sec. #**_____
if not mother or father

Employer of Responsible person_____ **Employers Address:**_____
if not mother or father *if different than mother or father*

Medical History

	YES	NO		YES	NO
• Heart Murmur	☐	☐	Congenital Heart Abnormality	☐	☐
• Rheumatic/Scarlet Fever	☐	☐	Hepatitis	☐	☐
• Jaundice	☐	☐	Bleeding Problems	☐	☐
• Bruise Easily	☐	☐	Does Patient Smoke	☐	☐
• Tonsils/Adenoids removed	☐	☐	Frequent Headaches	☐	☐
• Has patient reached puberty	☐	☐	Voice change/1st menses	☐	☐
• Allergies	☐	☐	If Yes, To what	_____	
• Allergies to Medications	☐	☐	If Yes, Type	_____	
• Does Patient Take Medication	☐	☐	If Yes, Name	_____	
• Has patient had major illness	☐	☐	If Yes, What	_____	
• Has patient been hospitalized	☐	☐	If Yes, for what	_____	

- Other pertinent medical history_____

_____

Dental History

	YES	NO
• Has Patient had injuries to face or jaw	☐	☐
• Is there clicking, popping, or pain in jaw joint	☐	☐
• Are there any speech problems	☐	☐
• Have any teeth been lost or broken	☐	☐
• Are there problems chewing, swallowing, or talking	☐	☐
• Do gums bleed on brushing or feel sore	☐	☐
• Are there any finger sucking habits/nailbiting	☐	☐
• Has patient been told of any extra or missing teeth by their Dentist	☐	☐
• Does patient brush their teeth at least every morning and night	☐	☐
• Does patient grind teeth at night	☐	☐
• Does patient snore during sleep	☐	☐
• Does patient play a musical instrument	☐	☐
• Is patient aware or concerned about appearance of the teeth	☐	☐
• Is patient interested in wearing orthodontic appliances to correct his/her teeth	☐	☐
• Has any other family member worn braces	☐	☐

- In your own words how would you describe the problem_____

_____

Signature *Date* *Relationship to Patient*