Child – Acquaintance Card

Patient Name _____
First Middle Last Nick Name

Birthday _____ Sex _____ SS# _____

Address _____City _____State_____ Zip_____

Home phone _____ Email address _____

Work Phone _____ Cell phone _____

Hobbies _____ School _____ Grade _____

Physician_____ Dentist _____ Last Seen _____

Who referred you to our practice? _____

List family members that are currently in our practice: _____

Names and ages of Additional Children: _____

Responsible Party Information

Responsible Party Name _____Relationship _____
First Middle Last

Birthday _____ SS# _____

Home Phone _____ Email address _____

Work Phone _____ Cell phone _____

Address _____ City _____State _____ Zip _____

Employer _____

Is this the financially responsible party ? _____ Yes _____ No

Is this the primary person who brings patient to appointment? _____ Yes _____ No

Responsible Party Name _____Relationship _____
First Middle Last

Birthday _____ SS# _____

Home Phone _____ Email address _____

Work Phone _____ Cell phone _____

Address _____ City _____State _____ Zip _____

Employer -_____

Is this the financially responsible party ? _____ Yes _____ No

Is this the primary person who brings patient to appointment? _____ Yes _____ No

Dental History

Has there been any injuries to the face, mouth or teeth? _____Yes _____ No. Describe _____

Has the patient ever sucked a thumb or fingers? _____ Yes_____No. Until what age? _____

Does the patient have any speech problems? _____Yes _____No.

Is the paient a mouth breather?While awake……_____ Yes _____ No. While asleep? _____ Yes_____ No

Does the patient have any missing or extra permanent teeth? _____Yes _____No

Has an orthodontist been previously consulted? _____Yes _____ No. Whom? _____

Has either parent had orthodontic treatment? _____Yes _____No. Which parent? _____

Has patient ever been treated for periododntal disease or TMJ? _____ Yes _____ No

Medical History

Is patient in good health? _____Yes ☐ No ☐

Does patient have any history of major illness _____Yes ☐ No ☐

Check any of the following for which patient has been treated:

__Diabetes	__Tuberculosis	__Prolonged Bleeding
__Pneumonia	__Anemia	__Endocrine Problems
__Heart trouble	__Epilepsy	__Fainting or Dizziness
__Rheumatic fever	__Asthma	__Nervous Disorders
__Bone disorders	__Kidney Involvement	__Liver Involvement
__Hepatitis	__Hypertention	__Thyroid Problems

Does patient have tendency to _____Colds _____ Sore Throats _____ Ear Infections

Have tonsils and adenoids been removed?____ Yes ____ No What age? _____

List any drugs or medications (prescribed or over the counter) now being taken: Give reason _____

Is premedication required for dental procedures?_____ Yes _____No Why? _____

List any allergies or drug sensitivy: _____

Has the patient reached puberty? Girls- has she started menstruation? _____Yes _____ No

Has the patient reached puberty? Boys- has his voice changed? _____Yes _____No

Reason for consultation: _____

Dental Insurance Infornation

Insured's name _____ Insured DOB _____/_____/_____

Insured SS# _____Insured ID# _____

Insurance Company _____

Insurance company address _____

Employer _____

Is policy connected with a Union? _____ Yes _____ No. Name of Union _____ Local # _____

Do you have dual coverage? ____Yes _____ No. If yes, please complete the following secondary insurance information.

Insured's name _____ Insured DOB _____/_____/_____

Insured SS# _____Insured ID# _____

Insurance Company _____

Insurance company address _____

Employer _____

Is policy connected with a Union? _____ Yes _____ No. Name of Union _____ Local # _____

I understand that the information that I have given today is corrected to the best of my knowledge. I also understant that this information will be held in the strictist confidence and it is my responsibility to inform this office of any changes in medical status. In case of seperation/divorce the parent that signs this medical history form will be responsible for all fees incurred at this visit. Please note that all responsible collection, legal costs, including but not limited to finance charges required to collect fees due Batastini Orthodontics, will be borne by the undersigned.

Parent/Patient/Guardian_____ Date _____