



# THOMAS A. BROWN, D.M.D.

## CHILD ORTHODONTIC ACQUAINTANCE SHEET

Member  
American Association of  
Orthodontists®



DATE \_\_\_\_\_ What do you prefer

Patient's Name \_\_\_\_\_ to be called? \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zipcode

How many years at this address? \_\_\_\_\_ Previous address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ School \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Physician \_\_\_\_\_ Dentist \_\_\_\_\_

Parent's Marital Status: Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

Father's Name \_\_\_\_\_ Complete Address \_\_\_\_\_

(if different from patient)  
Employer \_\_\_\_\_ How Long? \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Mother's Name \_\_\_\_\_ Complete Address \_\_\_\_\_

(if different from patient)  
Employer \_\_\_\_\_ How Long? \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Whom may we thank for recommending our office to you? \_\_\_\_\_

Do you have any other family members that may need orthodontic treatment? \_\_\_\_\_

What do you hope orthodontics will accomplish for you? \_\_\_\_\_

### RESPONSIBLE PARTY

Person responsible for account: (same as above) \_\_\_\_\_ (other) \_\_\_\_\_ Name: \_\_\_\_\_  
(If same as above, skip this section) (If other, proceed with following)

Address \_\_\_\_\_  
Street City State Zipcode

How many years at this address? \_\_\_\_\_ Previous address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_ Employer \_\_\_\_\_ How long? \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F

Relationship to patient \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

IF MARRIED, PLEASE GIVE FOLLOWING INFORMATION REGARDING SPOUSE:

Name \_\_\_\_\_ Employer \_\_\_\_\_ How Long? \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

### EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Complete address \_\_\_\_\_ Phone# \_\_\_\_\_

## PATIENT'S DENTAL HISTORY

Yes No

- Has the patient had any severe head or face injuries? Explain \_\_\_\_\_
- Has the patient had a history of thumb sucking or finger sucking?  Stopped? \_\_\_\_\_ When? \_\_\_\_\_
- Does the patient play any musical (wind) instruments? What? \_\_\_\_\_
- Has the patient consulted an orthodontist previously?
- Has the patient had any previous orthodontic treatment?
- Did either parent have orthodontic treatment?

Please check if there is a history of:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Clenching teeth                           | <input type="checkbox"/> Jaw Joint Soreness | <input type="checkbox"/> Ringing in the Ears        |
| <input type="checkbox"/> Grinding teeth                            | <input type="checkbox"/> Jaw Joint Clicking | <input type="checkbox"/> Restricted Jaw Opening     |
| <input type="checkbox"/> Muscular Soreness around the head or neck | <input type="checkbox"/> Jaw Joint Popping  | <input type="checkbox"/> Jaw Locking Open or closed |
| <input type="checkbox"/> Headaches(more than normal)               |   |   |

## PATIENT'S HEALTH HISTORY

- |   |  |                |
|---|--|----------------|
| Is the patient in good health?          | <input type="checkbox"/> yes <input type="checkbox"/> no | Explain: _____ |
| Any major or unusual illnesses?         | <input type="checkbox"/> yes <input type="checkbox"/> no | Explain: _____ |
| Currently taking medication?            | <input type="checkbox"/> yes <input type="checkbox"/> no | Reason: _____  |
| Currently being treated by a physician? | <input type="checkbox"/> yes <input type="checkbox"/> no | Reason: _____  |
| Allergies?                              | <input type="checkbox"/> yes <input type="checkbox"/> no | List: _____    |
| Drug sensitivity?                       | <input type="checkbox"/> yes <input type="checkbox"/> no | List: _____    |

Does the patient have or has the patient had any of the following?:

- |   |  |  |
|---|--|--|
| Yes No  | Yes No   | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Anemia  | <input type="checkbox"/> <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> <input type="checkbox"/> Frequent Cold or Flu   |
| <input type="checkbox"/> <input type="checkbox"/> Blood Diseases                                      | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis ?  |
| <input type="checkbox"/> <input type="checkbox"/> Prolonged Bleeding                                  | <input type="checkbox"/> <input type="checkbox"/> Diabetes             | <input type="checkbox"/> <input type="checkbox"/> Tonsils removed: Age _____   |
| <input type="checkbox"/> <input type="checkbox"/> Jaundiced   | <input type="checkbox"/> <input type="checkbox"/> Endocrine Problems   | <input type="checkbox"/> <input type="checkbox"/> Adenoiditis?   |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever                                     | <input type="checkbox"/> <input type="checkbox"/> Bone/Joint Disorders | <input type="checkbox"/> <input type="checkbox"/> Adenoids removed: Age _____  |
| <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever                                       | <input type="checkbox"/> <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> <input type="checkbox"/> Asthma   |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> <input type="checkbox"/> Herpes               | <input type="checkbox"/> <input type="checkbox"/> Mouthbreathing: Awake? <input type="checkbox"/> Asleep? <input type="checkbox"/> |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma  |  |  |
| <input type="checkbox"/> <input type="checkbox"/> Is the patient HIV positive?                        |  |  |
| <input type="checkbox"/> <input type="checkbox"/> Is the patient now, or ever been addicted to drugs? |  |  |
| <input type="checkbox"/> <input type="checkbox"/> Does the patient have AIDS?                         |  |  |

If there are any Yes answers, please explain \_\_\_\_\_

Is there any other information that may be helpful? \_\_\_\_\_

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**\*\*THIS OFFICE WILL NOT BE RESPONSIBLE FOR PROBLEMS ARISING FROM UNDISCLOSED OR INCORRECT INFORMATION\*\***

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_ Updated (date & initials) \_\_\_\_\_