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John M. Wirant, D.M.D.
Practice Limited to Orthodontics

C

ORTHODONTIC ACQUAINTANCE FORM

Date _____

Patient's Name _____ (Last / First / M.I.) Birthdate _____ (mm/dd/yy) Sex _____

Res. Address _____ Telephone _____

_____ ZIP _____

School _____ Grade _____ SS# _____

Father's Name _____ Occupation _____

Employed by: _____ Business Tel: _____

Business Address: _____ ZIP _____

Mother's Name _____ Occupation _____

Employed by: _____ Business Tel: _____

Business Address: _____ ZIP _____

Who does the child reside with: ☐ Mother ☐ Father ☐ Both Parents ☐ Other _____

Address of non-custodial parent (if applicable): _____

Names & ages of other children in family _____

E-Mail address for appointment reminders _____

MEDICAL HISTORY

Name of your child's physician: _____

Is your child in good health? . . . . . Yes ☐ No ☐

Has your child ever been hospitalized, had general anesthesia or Emergency room visits? . . . . . Yes ☐ No ☐ Don't Know ☐

If yes, please explain: _____

Are your child's immunizations up to date? . . . . . Yes ☐ No ☐ Don't Know ☐

Allergies (please list): _____

Past medications taken by child: _____

Daily medications child is now taking: _____

Has your child ever had or been treated by a physician for:

Problems at birth ..... ☐	Tuberculosis ..... ☐	Cleft lip/palate ..... ☐
Heart murmur ..... ☐	Liver Disease ..... ☐	Speech or hearing problems ☐
Heart disease ..... ☐	Kidney Disease ..... ☐	Eye problems ..... ☐
Rheumatic fever ..... ☐	Diabetes ..... ☐	Skin problems ..... ☐
Anemia ..... ☐	Arthritis ..... ☐	Tonsil/adenoid problems ..... ☐
Bleeding/hemophilia ..... ☐	Cancer ..... ☐	Sleep problems ..... ☐
Blood transfusion ..... ☐	Cerebral palsy ..... ☐	Emotional/behavior problems ☐
Hepatitis ..... ☐	Seizures ..... ☐	Other Please list: _____
AIDS or HIV ..... ☐	Asthma ..... ☐	_____

GIRLS - started menstruation *BOYS* - voice changed Yes ☐ No ☐

Height _____ Weight _____

Do you consider your child to be (check one): Advanced In learning ☐ Progressing normally ☐ Slow learner ☐

(other side)>>>>>

DENTAL HISTORY

What is your main concern about your child's dental condition? _____

_____

Name of your child's dentist: _____

City/Town _____ Phone Number _____

Yes ☐ No ☐ ?? ☐ Has your child ever had dental x-rays? Date of last x-rays: _____

Yes ☐ No ☐ ?? ☐ Will your child be uncooperative? If yes, please explain: _____

Yes ☐ No ☐ ?? ☐ Has your child experienced any complications following dental treatment? If yes, please explain:

_____

Yes ☐ No ☐ ?? ☐ Has your child had cavities and/or toothaches?

Yes ☐ No ☐ ?? ☐ Are your child's teeth sensitive to temperature, pressure or certain foods?

Yes ☐ No ☐ ?? ☐ Have you or your child ever received instruction on proper tooth brushing technique?

Yes ☐ No ☐ ?? ☐ Do your child's gums bleed when brushed? _____

Yes ☐ No ☐ ?? ☐ Does your child use fluoride products, rinses, drops, or tabs?

Yes ☐ No ☐ ?? ☐ Has your child had any clicking or pain in his/her jaw joints? If yes, please explain:

_____

Yes ☐ No ☐ ?? ☐ Has your child inherited any family facial or dental characteristics? If yes, please explain:

_____

Yes ☐ No ☐ ?? ☐ Is the child a mouth breather? While Awake? ☐ While asleep? ☐

Yes ☐ No ☐ ?? ☐ Has your child ever injured his/her teeth? _____

Yes ☐ No ☐ ?? ☐ Has your child ever injured his/her jaw or face? _____

Yes ☐ No ☐ ?? ☐ Have you been informed of any missing or extra permanent teeth?

Yes ☐ No ☐ ?? ☐ Did your child use a pacifier? _____

Yes ☐ No ☐ ?? ☐ Did your child suck his/her finger or thumb? Until what age? _____

Yes ☐ No ☐ ?? ☐ Has an orthodontist been consulted previously?

Yes ☐ No ☐ ?? ☐ Has either parent had orthodontic treatment? _____

Yes ☐ No ☐ ?? ☐ List any musical instruments played: _____

Does your child have any other dental problems we should know about? Yes ☐ No ☐ Please explain: _____

_____

Whom may we thank for referring you to our office? _____

How else did you hear about us? Check all that apply.

☐ Phone Book ☐ Sign/Banner ☐ Website

☐ Mailer/Magnet ☐ Doctor's Office ☐ Other _____

PERSON COMPLETING THIS FORM: Signature _____

Relationship to patient _____

Please do not forget to fill out a HIPAA privacy form. If you did not receive one, ask for one now.