Smiles by Dr.W & Dr.R

Peter S. Wohlgemuth, D.M.D., P.A.
Ira Rothstein, D.M.D., M.S.
Quality Orthodontics That Will Make You Smile

Orthodontic Acquaintance Form

Patient Name:_____ Sex: ☐ Male ☐ Female Birthdate: _____

Street: _____ City: _____ State:_____ Zip: _____

Telephone: Home: _____ Cell: _____ Office: _____

Employer: _____ Email Address: _____

School : _____ Grade: _____

Parent 1: _____ Marital Status: _____

Employer: _____ Occupation/Position:_____

DOB #: _____ Business Phone:_____

Cell Phone:_____

Parent 2: _____ Marital Status: _____

Employer: _____ Occupation/Position:_____

DOB #: _____ Business Phone:_____

Cell Phone:_____

Name and age of other family members:

NAME	BIRTHDATE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GUARANTOR: **Parent 1** **Parent 2** **Self** **Guardian**

Name: _____ Relation: _____ SSN #: _____

Street: _____ City: _____ State:_____ Zip: _____

ORTHODONTIC INSURANCE: _____ Insured SSN #: _____

Name of Subscriber:_____ Employer:_____

Subscriber's Date of Birth: _____ Group/Plan #:_____

Insurance Carrier: _____ Telephone: _____

Emergency Contact (than parent/spouse):

Name: _____ Phone:_____ Relationship to Patient: _____

Patient's Dentist:_____ Last Cleaning:_____

Patient's Physician: _____ Whom may we thank for referring you?_____

What are the main concerns regarding the patient's jaws and teeth?

☐ Crowding	☐ Prominent jaw	☐ Missing teeth	☐ Irregularly shaped teeth	☐ No concerns at all
☐ Over-bite	☐ Gummy smile	☐ Jaw dysfunction	☐ Protrusion of teeth	☐ Other_____
☐ "Buck" teeth	☐ Spaces	☐ Mouth too small	☐ Poor facial proportions	
☐ Receded jaw	☐ Gum disease	☐ Clicking jaw joint	☐ Headaches/facial pain	

MEDICAL / DENTAL HISTORY

1) ***Present Health***

	Good	Fair	Poor
a) Physical	☐	☐	☐
b) Emotional	☐	☐	☐

c) If a child; has patient reached puberty? ☐ Yes ☐ No

2) ***Are there any learning issues?*** (ADD, ADHD, Etc.) ☐ Yes ☐ No

3) ***Has the patient ever had any of the following conditions?***

- ☐ Aids
- ☐ Allergies (seasonal/environmental)
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Blood disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bone disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Other_____
- ☐ Epilepsy
- ☐ Endocrine problems
- ☐ Emotional problems
- ☐ Female problems
- ☐ Hepatitis
- ☐ Heart disease
- ☐ Hearing disorder
- ☐ Kidney disorder
- ☐ Rheumatic fever
- ☐ Ringing in ears
- ☐ Sleep disturbance
- ☐ Received trauma (teeth, face, jaws, or head)

4) ***MEDICATIONS: Current patient medications:***

- ☐ Heart medications_____
- ☐ Antiobotics_____
- ☐ Diet pills (diuretics)
- ☐ Ritalin, Concerta, Adderal, etc.
- ☐ Vitamins
- ☐ Aspirin therapy
- ☐ Birth control pills
- ☐ Sleeping pills
- ☐ Muscle relaxants
- ☐ Insulin
- ☐ Coumadin
- ☐ Other_____

Need to premeditate for dental work? ☐ Yes ☐ No

5) ***ALLERGIES: The patient demonstrates an allergic response to:***

- ☐ Antibiotics _____
- ☐ Pain Pills (codeine, etc. _____
- ☐ Dairy products
- ☐ Wheat, cereals
- ☐ Dyes in food
- ☐ Latex
- ☐ Other _____

6) ***Do any of the following apply to the patient:***

a) ***Snore when sleeping?*** ..... ☐ Yes ☐ No

b) ***Breathe through the mouth?***
(mouth breather vs. nose breather)
☐ Seldom ☐ Sometimes ☐ Usually

c) ***Frequent colds?*** ..... ☐ Yes ☐ No

d) ***Frequent sore throats or tonsillitis?*** ..... ☐ Yes ☐ No

e) ***Difficulty swallowing?*** ..... ☐ Yes ☐ No

f) ***Difficulty chewing?*** ..... ☐ Yes ☐ No

g) ***Pain of clicking in the jaw joints?*** ..... ☐ Yes ☐ No

h) ***Speech problems?*** ..... ☐ Yes ☐ No

7) ***Does the patient have any of the following habits?***

a) ***Thumb sucking?***
☐ Never ☐ Previously ☐ Presently

b) ***Finger sucking?***
☐ Never ☐ Previously ☐ Presently

c) ***Lip biting or sucking?*** ..... ☐ Yes ☐ No

d) ***Grinding of teeth?*** ..... ☐ Yes ☐ No

e) ***Tongue thrusting?*** ..... ☐ Yes ☐ No

f) ***Other habits:*** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PATIENT OR PARENT ATTITUDE REGARDING DENTAL CARE AND TREATMENT

1) ***Dental Checkups***

- ☐ Twice a year
- ☐ Once a year
- ☐ Only if urgent
- ☐ Never

2) ***Any unusual dental experience?*** ☐ Yes ☐ No

_____

_____

3) ***Aware of any orthodontic problems?*** ☐ Yes ☐ No

4) ***Interest in orthodontic treatment:***

- ☐ Wants treatment
- ☐ Unwilling but agree
- ☐ Treatment if necessary
- ☐ Uncooperative

5) ***Orthodontic Consultation prompted by:***

- ☐ Dentist
- ☐ Parent
- ☐ Physician
- ☐ Spouse
- ☐ Friend
- ☐ Patient
- ☐ Sibling

6) ***Previous Orthodontic Consultation or treatment?*** ☐ Yes ☐ No

7) ***Are there any medical, dental or surgical problems not covered above?***
☐ Yes ☐ No

NO PROTECTED PATIENT INFORMATION SHALL BE USED OR DISCLOSED IN ANY MANNER OTHER THAN IN CONFORMITY WITH HIPAA ACT OF 1996. OUR OFFICE POLICY IS AVAILABLE FROM OUR OFFICE MANAGER FOR YOU TO REVIEW.

_____

Signature (parent or responsible adult)