

CHILD ORTHODONTIC ACQUAINTANCE QUESTIONNAIRE

Patient's Name _____ Name Preferred _____ Male ___ Female ___
 Primary Tele# _____ Home Cell Birthdate _____ Patient's Age _____
 Address _____ Other City _____ State _____ Zip _____
 E-mail Address _____ School _____
 Parents: Married Separated Divorced Widowed
 FATHER _____ MOTHER _____
 Employer _____ Employer _____
 Position _____ Position _____
 Tele# _____ Work Cell Tele# _____ Work Cell

Financially Responsible Party

Name _____ (male / female) Relationship _____
 Address _____ City _____ State _____ Zip _____
 Phone# _____ (cell / home / office) Date of Birth _____
 Driver's Lic# _____ Social Security# _____

Are you here for orthodontic treatment (braces/Invisalign)? Yes No
 Ever consulted an **orthodontist**? Yes No
 Has patient ever been treated by an **orthodontist**? Yes No
 Who is your dentist? _____ When was the patient's last dental cleaning? _____
 Do you plan on relocating in the next 1-2 years? _____ How did you hear about us? _____
 Other children in the household & their ages? _____
 Have your other children been treated here or examined here? Yes No
 If "YES", who? _____
 Any problem with the patient's health now? Yes No
 Please list current medications: _____
 Have tonsils and/or adenoids been removed? Yes No
 Please place an "X" if the patient **has now or has ever** had the following:

<input type="checkbox"/> Heart defect, trouble, abnormality <input type="checkbox"/> Sensitive Gag Reflex <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Nickel Allergy <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Hepatitis or liver problems <input type="checkbox"/> Convulsions or seizures <input type="checkbox"/> Fainting spells <input type="checkbox"/> Nervous, emotional problems or hyperactivity <input type="checkbox"/> Now taking medication <input type="checkbox"/> Gum disease <input type="checkbox"/> Mouthbreathing or snoring <input type="checkbox"/> Shoulder or neck pains	<input type="checkbox"/> Speech abnormality or lisp <input type="checkbox"/> Soreness in jaws or teeth <input type="checkbox"/> Popping or noises in jaw joints <input type="checkbox"/> Ringing or buzzing noise <input type="checkbox"/> Difficulty opening or closing <input type="checkbox"/> Locking jaws open or closed <input type="checkbox"/> Frequent earaches or ear infections <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Thumb or finger sucking: active / previous <input type="checkbox"/> Tongue thrusting (circle) <input type="checkbox"/> Asthma <input type="checkbox"/> Nasal allergies or hay fever <input type="checkbox"/> Sensory issues and/or Autism Spectrum Disorder (ASD)
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Is pt being seen by a physician for any reason(s) other than yearly check-ups? Yes No
 If so, explain treatment: _____

The information above is correct and the insurance information is complete.

Parent's Signature _____ Date _____
 Parent's Signature _____ Date _____

INSURANCE INFORMATION

Please fill out information for each dental plan that the patient is covered under.

1. Dental Insurance Company _____
Toll Free Phone # _____
Subscriber's Name _____ Relation to Patient _____
Subscriber's Social Security # _____
Subscriber's Date of Birth _____
Employer _____
Plan # _____
Group # _____
Claim's Address _____

2. Dental Insurance Company _____
Toll Free Phone # _____
Subscriber's Name _____ Relation to Patient _____
Subscriber's Social Security # _____
Subscriber's Date of Birth _____
Employer _____
Plan # _____
Group # _____
Claim's Address _____

3. Dental Insurance Company _____
Toll Free Phone # _____
Subscriber's Name _____ Relation to Patient _____
Subscriber's Social Security # _____
Subscriber's Date of Birth _____
Employer _____
Plan # _____
Group # _____
Claim's Address _____

