(760) 729-8101 | 2515 Pio Pico Drive, Suite A, Carlsbad, CA 92008 | www.carlsbadortho.com

ORTHODONTIC ACQUAINTANCE CARD

Date__________________ 20_____

Date of Birth__________________

Patient's Name ____ Age ____ Sex ______
LAST FIRST

DENTAL HISTORY

Have There Been Any Injuries To The Face, Mouth Or Teeth? .... Yes No

Does The Patient Have Any Speech Problems? .... Yes No

Is The Patient A Mouth Breather? While Awake? .... Yes No

While Asleep? .... Yes No

Have You Been Informed Of Any Missing Or Extra Teeth? .... Yes No

Has An Orthodontist Been Consulted Previously? .... Yes No

Have You Ever Had Jaw Problems? .... Yes No

Please list any mouth related habits____

Reason for Present Consultation____

Patient's Dentist ______________________ Date of Recent Cleaning ______________

Patient's Physician____

MEDICAL HISTORY

Is Patient In Good Health? .... Yes No

Does Patient Have Any History Of Major Illness? .... Yes No

Is Patient Under Care Of A Physician Now? .... Yes No

Please Specify ____

Has the patient had any of the following (please circle):

Anemia	Fainting Or Dizziness	Kidney Problems
Arthritis	Headaches	Lower Back Pain
Asthma	Heart Condition	Neckaches
Bleeding Problems	Hepatitis - Liver Disease	Nervous Disorders
Diabetes	High Blood Pressure	Psychiatric Treatment
Epilepsy	H.I.V.	Tuberculosis

List Any Drugs Or Medications Now Being Taken, and Purpose ______________________________

____

Have Tonsils And Adenoids Been Removed?.......... Yes No

List Any Allergies Or Drug Sensitivity ____

Family History (optional) ☐ Biological Parents ☐ Step Parents ☐ Adoptive Parents

Please indicate outside interests and hobbies ____

Date____________

Confidential Patient Information

A B C

Patient's Name____
Last First Middle

Address____
Street City State Zip

Home Phone____________ Birthdate____________ Social Security #____________

If patient is a minor, give parent's or guardian's name____________________

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

Confidential Responsible Party Information

Name____ Marital Status________
Last First Middle

Residence____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address____________________________ Email____________________
Street City State Zip

How long at this address____________ Previous Address____________________
(if less than 3 yrs) Street City State Zip

Home Phone____________ Work Phone____________ Cell Phone____________

Social Security #____________ Birthdate____________ Relationship to Patient____________

Employer____________ Occupation____________ No. Years Employed____________

Name____ Marital Status________
Last First Middle

Residence____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address____________________________ Phone____________________
Street City State Zip

Social Security #____________ Birthdate____________ Relationship to Patient____________

Employer____________ Occupation____________ No. Years Employed____________

Insurance Information

Policy Holder's Name____________________________ and Soc.Sec. #____________

Insurance Company____________________ Group No.__________ Union Local No.__________

Insurance Co. Address____________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____________________________ and Soc. Sec. #____________

Insurance Company____________________ Group No.__________ Union Local No.__________

Insurance Co. Address____________________________ Insurance Co. Phone____________

Policy Holder's Employer____

Emergency Information

Name of nearest relative not living with you____________________________

Phone____________________ Relationship:____________________

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor)____

Updates (date & initial)____

CONFIDENTIAL (for record and pretreatment evaluation)

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