(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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