Dr. Joanne E. Collins
ORTHODONTIST

Child Orthodontic Acquaintance Form

Name: _____ Date: _____
Date of Birth: MM ____ DD ____ YY ____ Age: _____ Sex: _____ School: _____ Grade: _____
Home Address: _____ City: _____ Postal Code: _____
Child's Email: _____ Age & name of other children: _____
Patient's Dentist: _____ Physician: _____ Physician's Tel: _____
Parent/Guardian 1: _____ Home Tel: _____
Address: _____ City: _____ Postal Code: _____
Email Address: _____ Daytime Tel: _____ □ Cell □ Work □ Home
Parent/Guardian 2: _____ Home Tel: _____
Address: _____ City: _____ Postal Code: _____
Email Address: _____ Daytime Tel: _____ □ Cell □ Work □ Home
Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure
Person responsible for account: _____
Who may we thank for referring you? _____

MEDICAL HISTORY - HAS YOUR CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Epilepsy or Seizures	□ Yes □ No	Asthma	□ Yes □ No
Blood Pressure	□ Yes □ No	Cancer	□ Yes □ No	Arthritis	□ Yes □ No
Prolonged Bleeding	□ Yes □ No	Psychological Therapy	□ Yes □ No	Other _____	

If you responded YES to any of the above questions, please give pertinent information: _____
_____

Is your child in good health? _____
List any drugs or medications now being taken: Please give reasons: _____
Does your child have any history of major illness and/or operations? _____
Does your child have a history of malignant hyperthermia? _____
List any allergies or drug sensitivities: _____
Have tonsils or adenoids been removed? □ Yes □ No At what age? _____
Has your child reached puberty? □ Yes □ No

DENTAL HISTORY

Has your child ever been treated for a jaw joint problem, including surgery?		□ Yes □ No
Have there been any injuries to the face, mouth or teeth?	Please describe: _____	□ Yes □ No
Has your child ever sucked his/her thumb or finger?	Until what age? _____	□ Yes □ No
Does your child have any speech problems?		□ Yes □ No
Does your child have frequent canker or cold sores?		□ Yes □ No
Is your child a mouth breather?		□ Yes □ No
Have you been informed of any missing or extra permanent teeth?		□ Yes □ No
Girls: Has she started her menstrual cycle?		□ Yes □ No
Boys: Has his voice changed yet?		□ Yes □ No
Is the child especially apprehensive towards dental visits?		□ Yes □ No
Has the child ever had a previous orthodontic examination?		□ Yes □ No
Does your child want orthodontic treatment?		□ Yes □ No
Has any other family member had braces or orthodontic treatment?		□ Yes □ No

Please name the family member and who did the treatment: _____
When did your child last see the family dentist? _____
List any sports, hobbies or musical instruments played: _____
Reason for orthodontic consultation: _____

_____
Signature of Parent or Legal Guardian