

Orthodontics on Silver Lake, P.A.
Stephanie E. Steckel, D.D.S., M.S.
Welcome To Our Office
-Please Print-

ORTHODONTIC ACQUAINTANCE CARD

Date: _____ 20 _____

Date of Birth: _____

Patient's name: _____
First Middle Last

Name Patient Prefers to be Called: _____ Age: _____ Sex: Male Female

Telephone Number: _____ Other Phone: _____

Home Address: _____ Zip Code: _____

If lived at address less than five years, previous address: _____

School: _____ Grade: _____

Family Dentist: _____ Last Check Up: _____

How did you hear about our office: (check all that apply)

www.doverorthodontics.com Phone Book Dentist Internet _____

www.braces.org Patient/Relative/Friend: _____

Birth Father's Name: _____ DOB: _____ Soc. Sec. No.: _____

Occupation: _____ Employed By: _____

Years employed: _____ Business Telephone: _____

Business Address: _____

Birth Mother's Name: _____ DOB: _____ Soc. Sec. No.: _____

Occupation: _____ Employed By: _____

Years employed: _____ Business Telephone: _____

Business Address: _____

Parents Marital Status: Married Divorced Separated Single

Custodial Parent(s)/Guardian(s): _____

Names and Ages of Other Children in Family: _____

Person responsible for account: _____

*Who can have access to patients treatment records?: _____

Do you have any insurance coverage for orthodontic treatment? Yes No

Primary Policy Holder's Name: _____ ID Number: _____

Dental Insurance Company: _____ Group Number: _____

Claims Mailing Address: _____

Medical History

Is the patient under the care of a physician for a specific problem at the present time? Yes No

Illness: _____

List any medicines your child is currently taking: _____

List any drug sensitivities: _____

Is there a history of serious illness, accident, or operation? Yes No If so, List: _____

If female, are you, or might you be PREGNANT? Yes No

PLEASE CHECK THE FOLLOWING AS THEY APPLY

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma or Allergies | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Adopted | <input type="checkbox"/> Hepatitis/Liver Disease |
| <input type="checkbox"/> Animal Allergies | <input type="checkbox"/> AIDS, HIV+ | <input type="checkbox"/> Night Grinding of teeth | <input type="checkbox"/> Tuberculosis |

Has the patient reached puberty? Girls: Has she started menstruation? Yes _____ No _____

If Yes, Month/Year _____

Boys: has his voice change? Yes _____ No _____

Please complete the following information as accurately as possible to help us evaluate family growth pattern.

Father: Height _____ Mother: Height _____ Patient: Height _____ Weight _____

Dental History

Have there been any injuries to the face, mouth, or teeth? _____ Yes No D/K

Have you ever had gum disease? _____ Yes No D/K

Do you get "Gum Boils", frequent canker sores or sold sores? _____ Yes No D/K

Do you take any forms of fluoride? _____ Yes No D/K

Have you been informed of any missing or extra permanent teeth? _____ Yes No D/K

Any serious trouble associated with any previous dental treatment? _____ Yes No D/K

Has an orthodontist been consulted previously? If so by whom? _____ Yes No D/K

Has anyone in your family had orthodontic treatment? _____ Yes No D/K

Do you have an unusual amount of stress in your life? _____ Yes No D/K

Do you or have you ever smoked or chewed tobacco? _____ Yes No D/K

Please list any family members treated here _____

Reason for seeking orthodontic treatment (what Problem do you wish to have corrected?) _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

Patients Hobbies or Interest: _____

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Patient/Parent Signature

<p>For Office Use Only:</p> <p><input type="checkbox"/> ID Verification</p> <p>Present: Mom Dad Step-Mom Step-Dad</p> <p>Initials: _____</p>
