Child Orthodontic Acquaintance Form

Certified Specialists in Orthodontics – Dr. Norm Riekenbrauck, Dr. Steven Ma & Dr. Greg Hergott

Patients Name:_____ Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: M / F School: _____

Home Address: _____

Home Number: _____ Daytime: _____ Email: _____

Patient's Dentist: _____

Physician: _____ Physician's Number: _____

Who may we thank for referring you? _____

Mothers Name: _____ Fathers Name: _____ Same Address: ☐ Yes ☐ No

Mothers Address (if diff than patient): _____ Mothers Cell Number: _____

Fathers Address (if diff than patient): _____ Fathers Cell Number: _____

Do you have an insurance plan that covers orthodontic treatment? ☐ Yes ☐ No ☐ Unsure

MEDICAL HISTORY – HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Type 1 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
Heart Disease	☐ Yes ☐ No	Sexually Transmitted Diseases	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Blood Pressure	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Prolonged Bleeding	☐ Yes ☐ No	Bone/Osteoporosis	☐ Yes ☐ No

Other: _____

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

Are you in good health? ☐ Yes ☐ No If you responded 'No", please explain: _____

List any drugs or medications now being taken: Please give reasons: _____

Do you have a history of major illness and/or operations? _____

List any allergies or drug sensitivities: _____

Have you had your tonsils or adenoids removed: ☐ Yes ☐ No At what age: _____

Do you have a tendency for colds? ☐ Yes ☐ No Sore throats? ☐ Yes ☐ No Ear Infections? ☐ Yes ☐ No

(Women) Are you pregnant? ☐ Yes ☐ No

DENTAL HISTORY

Have you ever been treated for jaw joint problem, including surgery?	☐ Yes ☐ No	
Have there been any injuries to the face, mouth or teeth?	☐ Yes ☐ No	Please describe: _____
Have you ever sucked your thumb or finger?	☐ Yes ☐ No	Until what age? _____
Do you have any speech problems?	☐ Yes ☐ No	
Do you have frequent cankers or cold sores?	☐ Yes ☐ No	
Are you a mouth breather? While asleep?	☐ Yes ☐ No	While awake? _____
Have you ever been informed of any missing or extra permanent teeth?	☐ Yes ☐ No	
Have you ever had a previous orthodontic evaluation?	☐ Yes ☐ No	
Do you want orthodontic treatment?	☐ Yes ☐ No	
Has any other family member had brace or orthodontic treatment?	☐ Yes ☐ No	

Please name the family member if treated in our office: _____

When did you last see your dentist? _____

Reason for orthodontic consultation: _____

Hobbies: _____

I, the guardian, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____

Guardian Signature Date