

RADNEY · SCOTT ORTHODONTICS
ORTHODONTIC ACQUAINTANCE CARD



DATE _____

PLEASE PRINT

PATIENT INFORMATION

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip Code

Email Address for appointment reminders _____

Home Phone _____ Age _____ Birthdate _____ Sex _____

Hobbies _____

RESPONSIBLE PARTY INFORMATION

Name _____
Mrs. Ms. Last First Middle Marital Status
Mr. Dr.

Address _____
Street City State Zip Code

How long at this address? _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Previous Address (If less than 3 years) _____
Street City State Zip Code

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employed By _____ Occupation _____ No. of years employed _____

Spouse's Name _____

Spouse Employed By _____ Occupation _____

Spouse's Social Security Number _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security Number _____

Insurance Company _____ Group Number _____ Local Number _____

Insurance Company Address _____
Street City State Zip Code

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest friend or relative not living with you _____

Complete Address _____
Street City State Zip Code Phone

GENERAL INFORMATION

Friends or relatives treated here _____

Names and ages of other children in family _____

Patient's Dentist _____ City _____

Dental Examination within last six months? _____ If yes, date of last visit _____

Reason for seeking orthodontic treatment _____

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

MEDICAL HISTORY

Family Physician _____ City _____

Have you ever had or presently have:

- | | | | |
|---------------|--------------------|---------------------|------------------------|
| AIDS | Bone Disorders | Emotional Problems | Hepatitis |
| Asthma | Diabetes | Heart Disease | Rheumatic Fever |
| Anemia | Epilepsy | Hearing Disorder | Herpes |
| Blood Disease | Endocrine Problems | Head or Face Injury | Other (Describe Below) |

Do you:

- | | | | | | |
|-----------------------|----------------------------|------------------------|-------------------|-------------|-------------|
| Have allergies to: | Seasonal Grasses _____ | Food _____ | Drugs _____ | Latex _____ | Other _____ |
| Have habits: | Thumb/Finger Sucking _____ | Tongue Thrusting _____ | Nail Biting _____ | Other _____ | |
| Breathe through mouth | | no | yes | sometimes | |
| Tonsils removed | | no | yes | when? _____ | |
| Adenoids removed | | no | yes | when? _____ | |

Have you had or do you have any form of osteoporosis? yes no

Have you taken or do you take any medication for osteoporosis? yes no

Present drugs or medications: _____

Have you been under the care of a physician during the past two years, other than routine examination? no yes (if yes, please describe below)

DENTAL AND JAW (TMJ) JOINT HISTORY

Have you had any serious injuries or blows to the mouth? yes no Treatment? yes no (describe)

Do you experience any:

- | | | |
|---|-----|----|
| Pain or limitation of movement of the lower jaw? (chewing difficulty) | yes | no |
| Any popping, cracking, or grinding noises when the jaw is opened or closed? | yes | no |
| Frequent head or neck aches? | yes | no |
| Pain or ringing in the ears? | yes | no |
| Do you clench or grind your teeth? | yes | no |
| Has your jaw ever locked or slipped out of place? | yes | no |

ORTHODONTIC INFORMATION

Who noticed your orthodontic problem first? self dentist friend other _____

Have you had previous orthodontic consultation? yes no

treatment? yes no

Date _____ Doctor: _____

What is your attitude toward wearing "braces"?

- a.) excited b.) complacent/resigned c.) antagonistic/unwilling

Has any other member of the family had orthodontic treatment? yes no

Is patient interested in having treatment for:

- | | | |
|----------------------|------------------------------|---|
| a.) apperance | c.) better speech | e.) reduction in jaw or face discomfort |
| b.) better digestion | d.) better bite relationship | f.) preventing gum problems |

Are you seeking an esthetic option such as: Incognito lingual braces, Invisalign or clear porcelain brackets

Our Office is HIPPA compliant and I have been given a copy of the Notice of Privacy Practices. Also, I understand that where appropriate, credit bureau reports may be obtained.

This form was completed by:

Signature _____