

# MERIDIAN PARK ORTHODONTICS

## YOUTH ACQUAINTANCE FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Nick Name \_\_\_\_\_  
 BirthDate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Brothers (Name & Age) \_\_\_\_\_ Sisters (Name & Age) \_\_\_\_\_  
 Has any member of your family been a patient in this office?  Yes  No Names \_\_\_\_\_  
 Do you know anyone who is a patient in our practice?  Yes  No Names \_\_\_\_\_  
 Referred By \_\_\_\_\_ Dentist (Name & City) \_\_\_\_\_ Physician (Name & City) \_\_\_\_\_  
 Hobbies and Interests \_\_\_\_\_  
 Email \_\_\_\_\_ Would you like us to confirm appointments via email? \_\_\_\_\_

	FATHER	MOTHER	STEPMOTHER/FATHER
Name			
Address			
Date of Birth			
Cell Phone			
Home Phone			
Occupation			
Employer/Business			
Business Phone			
SSN			
Orthodontic Ins. Co.			
Group #			

Do Mother, Father and Child all live together?  Yes  No If not who does child live with? \_\_\_\_\_  
 Person responsible for this account \_\_\_\_\_ Is your child adopted?  Yes  No

### MEDICAL HISTORY

Have you been diagnosed or treated for any of the following?

- |                          |                          |                             |                          |                             |                          |
|--------------------------|--------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|
| Yes                      | No                       | Yes                         | No                       | Yes                         | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> |
| Diabetes                 |                          | Bone Disorders/Osteoporosis |                          | Ear Infections              |                          |
| Heart Trouble            |                          | Emotional Problems          |                          | Mononucleosis               |                          |
| Rheumatic Fever          |                          | Anemia                      |                          | Thyroid Problems            |                          |
| Tuberculosis             |                          | HIV/AIDS                    |                          | Fainting or Dizzy Spells    |                          |
| Cancer                   |                          | Pneumonia                   |                          | Prolonged Bleeding          |                          |
| Epilepsy                 |                          | Asthma                      |                          | Adenoids Removed, Age _____ |                          |
| Hepatitis                |                          | Frequent colds and/or flu   |                          | Tonsils Removed, Age _____  |                          |

List any other illnesses or medical problems \_\_\_\_\_

List any allergies (including those to any drugs or medications) \_\_\_\_\_

List any drugs or medications now being taken \_\_\_\_\_

GIRLS: Has she started menstruation?  Yes  No BOYS: Has his voice changed?  Yes  No

### DENTAL HISTORY

Have you ever sucked a thumb or finger? Until what age? \_\_\_\_\_

Do you have any speech problems? Any speech therapy? \_\_\_\_\_

Do you clench or grind your teeth? At night? \_\_\_\_\_

Do you have pain or clicking upon opening or closing your mouth? \_\_\_\_\_

Have you had any severe head or face injuries? Were any teeth injured or chipped? \_\_\_\_\_

Have you been informed of any extra or missing permanent teeth? Which? \_\_\_\_\_

Is there any noticeable difficulty in chewing or swallowing food? \_\_\_\_\_

Would you mind wearing braces? \_\_\_\_\_

Are you aware of any tongue thrusting problems? \_\_\_\_\_

Facial appearance most resembles  Father  Mother  Neither \_\_\_\_\_

Has either parent had orthodontic treatment? Which? \_\_\_\_\_

Have you consulted with another orthodontist? \_\_\_\_\_ Any previous orthodontic treatment? \_\_\_\_\_

Date of last dental appointment \_\_\_\_\_ Were x-rays taken? \_\_\_\_\_

Are you aware that some appointments will infringe upon work/school time? \_\_\_\_\_

In your own words, what is the problem? \_\_\_\_\_

What would you like orthodontic treatment to accomplish? \_\_\_\_\_

Do you have any special concerns about undergoing orthodontic treatment? \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_