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_____ Musical Instruments _____

	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	
☐	☐	Diabetes	☐	☐	Epilepsy	☐	☐	Ear Infections
☐	☐	Heart Trouble	☐	☐	Emotional Problems	☐	☐	Mononucleosis
☐	☐	Rheumatic Fever	☐	☐	Anemia	☐	☐	Thyroid Problems
☐	☐	Tuberculosis	☐	☐	HIV/AIDS	☐	☐	Fainting or Dizzy Spells
☐	☐	Bone Disorders	☐	☐	Pneumonia	☐	☐	Prolonged Bleeding
☐	☐	Asthma	☐	☐	Frequent colds and/or flu	☐	☐	Adenoids Removed, Age_____
						☐	☐	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? _____

Have any teeth been injured or chipped due to accidents? _____

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? _____

Date of last dental appointment _____ Where 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** _____