

**ACQUAINTANCE AND HISTORY QUESTIONNAIRE**

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Practice Limited to Orthodontics

**Please Print**

Patient's name \_\_\_\_\_ Birthday \_\_\_\_\_

Name patient prefers to be called \_\_\_\_\_ Sex M F

Family e-mail \_\_\_\_\_ Grade \_\_\_\_\_

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_

Address \_\_\_\_\_ Home phone \_\_\_\_\_

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Father's occupation \_\_\_\_\_ Business phone \_\_\_\_\_

Mother's occupation \_\_\_\_\_ Business phone \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Address \_\_\_\_\_

Whom may we thank for recommending our office to you? \_\_\_\_\_

What problem(s) about the patient's teeth led you to seek our advice? \_\_\_\_\_

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Is the patient presently in excellent health? YES \_\_\_\_\_ NO \_\_\_\_\_

Is the patient taking any medications or being Treated by a physician? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Are you a permanent resident of the Chapel Hill/Hillsborough area YES \_\_\_\_\_ NO \_\_\_\_\_

If no, how long do you expect to be in this area? \_\_\_\_\_

- over please -

Please check any of these the patient has had:

YES	NO		YES	NO	
___	___	hepatitis	___	___	frequent headaches
___	___	tuberculosis	___	___	diabetes
___	___	frequently stuffed nose	___	___	epilepsy
___	___	thumb or finger sucking (age stopped ___)	___	___	heart disease
___	___	fainting or dizzy spells	___	___	tonsils removed
___	___	allergies or asthma	___	___	speech problems
___	___	HIV positive/AIDS	___	___	hearing problems
___	___	premedication for dental procedures	___	___	bleeding problems
___	___	nervous or emotional disturbance	___	___	rheumatic fever
___	___	night grinding of teeth	___	___	psychiatric treatment
			___	___	injury to mouth
			___	___	pain related to teeth or jaw

Additional information or comments on the above responses \_\_\_\_\_

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Has the patient been growing rapidly recently? YES \_\_\_ NO \_\_\_

Girls: Has menstruation begun? YES \_\_\_ NO \_\_\_ at what age (year, month) \_\_\_\_\_

Does the patient play a musical instrument? YES \_\_\_ NO \_\_\_ if yes, please name \_\_\_\_\_

Additional information you feel would make your child's association with us more enjoyable:

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Have any other member of your family had more or less than  
The normal number of teeth to form? YES \_\_\_ NO \_\_\_

Have any other family members had orthodontic treatment? YES \_\_\_ NO \_\_\_

If treatment is performed here, please list the person accepting financial responsibility:

Name \_\_\_\_\_ e-mail \_\_\_\_\_  
If different than patient name

Address \_\_\_\_\_ Phone \_\_\_\_\_

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Parent's/Guardian Signature

Today's Date