South Hills Orthodontic's Acquaintance Form (Please Print)

Patient's Full Name_____ Date _____
Nickname (name called by) _____ ☐ Male ☐ Female
Age _____ DOB _____ - _____ - _____ School (if appl.) _____
Address _____ Home Phone _____
City _____ State _____ Zip Code _____
Employed By _____ Work Phone _____
Parents Marital Status (if appl.) ☐ Single ☐ Divorced ☐ Married ☐ Other
Give names of friends or family we have seen _____
Referred By_____ Brothers/Sisters name and age _____
Patient's Physician _____ Patient's Dentist _____
Person responsible for account _____ SSN _____ - _____ - _____
Address (if different than patient) _____

For patients who are minors, please complete the following

Father's Name _____Primary Phone _____
Employed By _____ SSN _____ - _____ - _____
Business Address _____Work Phone _____
Mother's Name _____ Primary Phone _____
Employed By _____ SSN _____ - _____ - _____
Business Address _____Work Phone _____
Parents Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Other
Insurance company _____ Group # _____

MEDICAL HISTORY *(circle yes or no to each question)*

Is patient in good health?.....	Yes	No
Does patient have any history of major illness?.....	Yes	No
Is pre-medication required for any dental procedure?.....	Yes	No
Is patient under the care of a physician?.....	Yes	No

If yes, for what? _____
Please list any allergies to medications _____

Indicate which of the following the patient has had, or has as of present

Diabetes	Yes	No	Fainting or Dizziness	Yes	No
Pneumonia	Yes	No	Psychiatric Care	Yes	No
Heart Trouble	Yes	No	Nervous Disorder	Yes	No
Rheumatic Fever	Yes	No	Liver Involvement	Yes	No
Mitral Valve Prolapse	Yes	No	Endocrine Problems	Yes	No
Heart Murmur	Yes	No	Hepatitis A (Infectious)	Yes	No
Artificial Joins	Yes	No	Hepatitis B (Serum)	Yes	No
Bone Disorders	Yes	No	H.I.V. positive	Yes	No
Anemic	Yes	No	Allergies	Yes	No
Epilepsy	Yes	No	Hemophilia	Yes	No
Asthma	Yes	No	Blood Transfusions	Yes	No
Kidney Involvement	Yes	No	Latex Sensitivity	Yes	No

Do you have any disease or problem not listed above? _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth?.....	Yes	No
Has the patient ever sucked a thumb or fingers? Until what age?.....	Yes	No
Does the patient have any speech problems?.....	Yes	No
Is the patient a mouth breather? While Awake?.....	Yes	No
While Asleep?.....	Yes	No
Have you been informed of any missing or extra permanent teeth?.....	Yes	No
Has an orthodontist been consulted previously?.....	Yes	No
Has either parent had orthodontic treatment?.....	Yes	No

List any musical instruments played and hobbies _____

Reason for consultation _____

Patient's Signature _____ Doctor's Signature _____