

Patient:	
Date:	

ORTHODONTIC ACQUAINTANCE CARD		
Date:		
Patient's DOB:		
	 Age:Sex:	
If Patient is over 18:		
Employer:	Work and/or Cell Phone:	
If Patient is under 18	:	
	Address (if different):	
Fmplover:	Work and/or Cell Phone:	
Email:		
Father's Name:	Address (ifdifferent):	
Employer:	Work and/or Cell Phone:	
Email:		
Family Dentist:	Referred by:	
	other Children:	
_	Iame:Patient's Hobbies/Interests:	
Medical History		
Is the patient in good	d health?YesNo If no, please give details:	
Doest the patient ha	ve any:History of major illness/hospitalization? Please	
explain:		
	sensitivities? Please explain:	
	any medications currently, if so what?Yes:	
-	reated by a physician for any condition, if so what?Yes:	
Has the patient (if fe	male and under 16) started menstruationNoYes: When?	
Please check any of t	the following for which the patient has been treated:	
	6 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Diabetes	Anemia ADD ADD	
Epilepsy	Fainting/Dizziness Heart Trouble Asthma Asthma	
	Rheumatic Fever Kidney Involvement	
	Tuberculosis Endocrine Problems Blood Disorder	
	Prolonged Bleeding Nervous Disorders Bone Disorder	
5 (14)		
Dental History		
	any injury to the face, jaws or teeth, if so please explain?Yes:	
	k their thumb?YesNo If they have stopped, at what age?	
•	regular dental visits in the past (every 6-12 months)?YesNo	
_	with an orthodontist previously?YesNo	
what is your (and the	e patient's) primary reason for today's consultation?	