



BURROW & CASE ORTHODONTICS

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DIPLOMATES AMERICAN BOARD OF ORTHODONTICS

PATIENT ACQUAINTANCE FORM

Date: _____

Patient's Name _____
Last First Middle (Sex)

Address _____
P.O. Box Street City State Zip

Home Phone _____ Birthdate _____ Age _____ SS# _____

If patient is a minor, please give parent's or guardian's name: _____

Whom may we thank for referring you to our office: _____

Has any member of your family or a friend been seen previously in this practice? _____

Name of school you attend: _____ Dentist: _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____
P.O. Box Street City State Zip

Mailing Address _____
P.O. Box Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

E-Mail Address (responsible party) _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Social Security # _____ Birthdate _____
Last First Middle

Spouse's Employer _____ Occupation _____ Work Phone _____

Does patient (if child) live with both parents? Yes _____ No _____

(If Divorced)

Other Parent's Name _____ Employer _____
Last First Middle

Other Parent's Address _____ Phone _____

Do you have orthodontic insurance? Yes _____ No _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____ Phone _____

Address _____

I agree that all of the above information is correct.

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor) _____



Patient: _____ Date: ____/____/____
Date of Birth: ____/____/____ Age: _____ Sex: M F

Medical History

Patient's Physician:

- Are you in good health? Yes No Explain: _____
- Do you have any history of major illness or hospitalization? Yes No Explain: _____
- Are you currently under the care of a physician? Yes No Explain: _____
- Do you currently take any medications? Yes No List & explain: _____

- Are you allergic/sensitive to any medications? Yes No List & explain: _____
- Do you frequently get colds? Yes No
- sore throat? Yes No
- ear infections? Yes No
- Have your tonsils and adenoids been removed? Yes No When? _____
- Did you have a blood transfusion prior to March 1985? Yes No
- If Yes, have you been tested for HIV/AIDS and hepatitis since then? Yes No
- Do you currently have or have you ever had any of the conditions listed below? Please check the appropriate response:

Yes	No		Yes	No		Yes	No	
___	___	Heart Attack	___	___	Anemia	___	___	Tuberculosis
___	___	Heart Murmur	___	___	Bleeding Disorders	___	___	Asthma
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Herpes
___	___	Rheumatic Heart Disease	___	___	HIV/AIDS	___	___	Kidney Disorders
___	___	Congenital Heart Defect	___	___	Diabetes	___	___	Epilepsy
___	___	Stroke	___	___	Leukemia	___	___	Fainting/Dizzy Spells
___	___	Mononucleosis	___	___	Bone Disorders	___	___	Endocrine Disorders

Children/Teens Only

- Has either parent had orthodontic treatment? Yes No Explain: _____
- Has the patient reached puberty? Yes No
- Boys: has his voiced changed? Yes No
- Girls: has she started menstruation? Yes No
- Height: _____ feet _____ inches •Weight: _____ lbs

Dental History

Patient's Dentist:

Patient's Oral Surgeon:

- When was your last dental exam/cleaning? _____
- Do you have any extra teeth? Yes No
- missing teeth? Yes No
- loose teeth? Yes No
- sensitive teeth? Yes No
- Have you ever had any injuries to your face, mouth, or teeth? Yes No Explain: _____
- Have you ever sucked your thumb or fingers? Yes No Explain: _____
- Do you have any speech problems? Yes No Explain: _____
- Are you a mouth-breather while awake? Yes No
- while asleep? Yes No
- Do you have any clicking, popping, or pain in your jaw joint (TMJ)? Yes No Explain: _____
- Do you clench or grind your teeth? Yes No
- Do you suffer frequent headaches? Yes No
- Does your jaw ever hurt? Yes No Explain: _____
- Have you ever had an orthodontic evaluation before today? Yes No
- When? _____
- May we ask who you saw? _____
- In your own words, please tell us why you are interested in orthodontic treatment: _____

The information given about my health history in this form is accurate and complete to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests, including x-rays, and to evaluate my dental health.

Signature of patient, parent, or guardian: _____ Date: ____/____/____

