BURROW ORTHODONTICS

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Diplomate American Board of Orthodontics
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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: _____

Hobbies/Activities:_____

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_____Cell Phone_____Work Phone _____

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

E-Mail Address (responsible party) _____

Social Security #_____ Birthdate_____ Relationship _____ DL State /ID#_____

Employer Occupation No. Years Employed_____

Spouse's Name_____Social Security #_____Birthdate_____
Last First Middle

Spouse's Employer_____Occupation_____ Work Phone_____

DL State / ID _____ 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)_____

EHASO THE ANGLE SOCIETY

DIPLOMATES AMERICAN BOARD OF ORTHODONTICS

Members American Association of Orthodontists

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OVER PLEASE

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

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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

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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:**_____/_____/___