ORTHODONTIC ACQUAINTANCE CARD

PATIENT'S NAME _____ DOB _____ Sex: M F

Age _____ Weight _____ Height _____ Marital Status _____

Address _____ City _____ Zip _____

Phone # _____ Employed by _____ Occupation _____

Work Address _____ Work # _____

Patient's Dentist _____ Dentist's Phone # _____

Dentist's Address _____ City _____ Zip _____

Referred by _____ Do you have Orthodontic Insurance? Y N

If Yes, Name of Insurance _____ Address _____

If no, Name of responsible Party _____

Address _____ City _____ Zip _____

WHAT IS YOUR PRESENT DENTAL PROBLEM? _____

ARE YOU HAVING ANY DISCOMFORT OR PAIN? YES NO

IF YES, WHERE? _____

Date of last Dental Exam _____

MEDICAL HISTORY

Are you now or have you been in the last two years under the care of a physician?.....

Have you ever had any serious illness?..... [ ] Yes [ ] No

Are you taking any medications (vitamins, cortisone (within past year), oral contraceptives, medicines, or drugs) at the present time?..... [ ] Yes [ ] No

Have you ever had or been treated for heart trouble, rheumatic fever, abnormal blood pressure, thyroid, stomach ulcer, hay fever, asthma, allergies, sinusitis, diabetes, epilepsy, gall bladder, tuberculosis, kidney or liver involvements, joint problems, anemia, hysterectomy, blood disorder cancer, eye trouble. CIRCLE THE APPROPRIATE ONES.

Have you ever had any adverse effects from any anesthetics, antibiotics, or any other drugs?.... [ ] Yes [ ] No

DENTAL HISTORY

Have you ever had an acute sore mouth?..... [ ] Yes [ ] No

Do you have frequent fever blisters on your lips or mouth?..... [ ] Yes [ ] No

Have you ever had burning of the tongue or crackling of the corners of your mouth?..... [ ] Yes [ ] No

Do your gums bleed_____When?..... [ ] Yes [ ] No

Are you aware of a bad taste in your mouth?..... [ ] Yes [ ] No

or odor in your mouth?..... [ ] Yes [ ] No

Are you troubled with frequent gum boils?..... [ ] Yes [ ] No

Do you grind your teeth at night?..... [ ] Yes [ ] No

Does your jaw ever get "out of joint"?..... [ ] Yes [ ] No

Do you ever have pain opening or closing your mouth?..... [ ] Yes [ ] No

Does your jaw ever "click"?..... [ ] Yes [ ] No

Did you ever wear braces for straightening your teeth??..... [ ] Yes [ ] No

Have you had periodontal treatment?..... [ ] Yes [ ] No

Are you bothered by tooth sensitivity? Hot? Cold? Sweets?..... [ ] Yes [ ] No

Signature_____ **Date**_____

EXAMINATION CHART

EXAM DATE _____

RE EXAM _____

RE EXAM _____

1. Profile: flat convex concave mild mod severe
2. Dentition: normal pro ret max mand bimax
3. Lips: normal parted everted
4. Symmetry: chin R L
5. Habits observed: TT MB LB_____
6. Hygiene_____ X per day P F G E
7. Soft tissue: normal gingivitis NUG
8. Frenum: normal enlarged max mand
9. Questionable lesions: none_____
10. Caries: low mod severe neglected
11. Teeth:

Right								Left							

D- Decalcified
F. Fractured
C-Caries
S-Supernumerary
I-Impacted
O- Submerged
X-extracted
E-ectopic
M- Cong. Missing
A- Atypical or Malformed

12. Eruption time: normal early delayed
13. Prolonged retention of deciduous teeth:
14. Early loss of teeth: decid perm
15. Migrated: to mes dist
16. Class: I II III Div 1 2 mod severe

	R	L
Molar		
Cuspid		

Diagnosis:

17. Overbite: norm deep impinging open_____ mm
18. Overjet:_____ mm
19. Curve of Spee: flat mild mod severe
20. Midline diastema:_____ mm familial frenum
21. TMJ: norm clicks pain Limited movement
22. Path of closure: ant post R L
23. Cross bite: unilat R L bilat ant
24. Disharmony of arches: max wide narrow
    mand wide narrow
25. Midline_____|_____ mm
    mm
26. Crowding or rotations:
27. CO=CR
28. Attached Gingivae

RECOMMENDATIONS:

- ❑ Records and consult
- ❑ Recall
- ❑ Extractions
- ❑ Space maintainers
- ❑ No treatment

Fee for Exam _____ R&C _____ Estimated fee _____ Estimated treatment time _____

Other _____

_____

❑ Request x-rays from Dr. _____

Parent will: ❑ follow recommendations ❑ call back

Send letter(s) to source of referral _____ and/or Dr._____

Date	Service	Time	Next Treatment	Appt