ORTHODONTICS AQUAINTANCE CARD

Date: _____ **Doctor:** _____

Patient No. _____

PATIENT INFORMATION

Last Name	First Name	Nickname	SS Number	Date of Birth
Address	City	State	Zip Code	Phone
School (if student) / Grade	Single | Married | Divorced Separated | Widow(er)	Employed By/Occupation		Work Phone
Referred By	Name of General Dentist	Date of Last Visit		

PARENT INFORMATION (please complete if patient is a minor)

Father's Name	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)	Mailing Address	City	State	ZIP	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Work Phone
Mother's Name	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow(er)	Mailing Address	City	State	ZIP	Home Phone
Social Security No.		Birthdate	Employed By/Occupation			Work Phone
Who has legal custody of this child? Mother Father Other		Other family members seen by us:				

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

Name	Relationship to Patient	Employed By/Occupation		Phone
Mailing Address	City	State	ZIP	Business Phone
Spouse's Name	Employed By/Occupation			Work Phone

MEDICAL/DENTAL HISTORY

Is the patient in good health? _____ Yes No

Does the patient have any history of major illness? _____ Yes No

_____

Has the patient ever been under the care of a physician? _____ Yes No

Please list: _____

Has the patient had any operations? _____ Yes No

Has the patient had any stays in the hospital? _____ Yes No

Has there been any injury 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? Whlie asleep? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has either parent had orthodontic treatment? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Has the patient reached puberty? _____ Yes No

Girls- Has she started menstruation? At what age? _____ Yes No

Boys- Has his voice changed? At what age? _____ Yes No

Have tonsils and adenoids been removed? At what age? _____ Yes No

Height: _____ Weight: _____

Please list any drugs or medications now being taken. Give reason.

_____

_____

List any allergies or drug sensitivities. _____

Please check any of the applicable conditions or problems

- ☐ Asthma
- ☐ Bone (fracture)
- ☐ Cancer
- ☐ Seizures
- ☐ Diabetes
- ☐ Endocrine (Hormone)
- ☐ Epilepsy
- ☐ Emotional Disorder
- ☐ Excessive Bleeding
- ☐ Eyes
- ☐ AIDS
- ☐ Prosthesis
- ☐ Other
- ☐ Fainting/Dizziness
- ☐ Hearing
- ☐ Heart Trouble
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Kidney Trouble
- ☐ Liver Trouble
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Speech Disorder
- ☐ Tuberculosis
- ☐ Hepatitis

INSURANCE: We do not accept assignment of Dental Insurance; however, we will be happy to file primary insurance for you. Do you intend to file for insurance benefits? Yes ____ No ____

Name of Company _____

I hereby authorize Hattiesburg Orthodontics, PLLC to furnish information to insurance carriers concerning my/my child's treatment. I understand that I am responsible for the full amount of my bill.

_____

Signature (patient, or parent if minor) Date

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney service to secure payment of this account.

_____

Signature (patient, or parent if minor) Date