ANDREW B. BROWN, D.D.S, M.S.
Welcome to Our Office

ORTHODONTIC ACQUAINTANCE CARD

DATE_____

— Please Print —

Date of Birth _____

Patient's Name _____ Age _____ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers to be Called _____ Home Telephone Number _____

Home Address _____
Street City State Zip

Cell Phone _____ Email _____

School _____ Grade _____ Last Visit to Dentist _____

Patient's Hobbies or Interests _____

Patient's Dentist _____ Physician _____

Whom may we thank for referring you? _____

Father's Name _____ Occupation _____

Employed by _____ Business Telephone _____

Business Address _____ Soc. Sec. No. _____

Mother's Name _____ Occupation _____

Employed by _____ Business Telephone _____

Business Address _____ Soc. Sec. No. _____

Name of Person Responsible for Account _____

Relationship to Patient _____

Marital Status Married ☐ Divorced ☐ Separated ☐ Single ☐

Do you have dental insurance that covers orthodontic treatment? Yes ☐ No ☐

Name of Insurance Company _____

Is orthodontic coverage with mother, father, both, or other? _____

MEDICAL HISTORY

Is the patient under the care of a physician for a specific problem at the present time? Yes ☐ No ☐ Illness _____

List any medications your child is currently taking _____

List any drug sensitivities _____

Is there a history of serious illness, accident or operation? Yes ☐ No ☐ If so, list _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems	☐ HIV
☐ Glaucoma	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems	☐ Venereal Disease
☐ Heart Trouble	☐ Tonsilitis	☐ Diabetes	☐ Endocrine Problems	☐ Pregnant
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorders	
☐ Hepatitis/Liver Disease	☐ Ear Infections	☐ Epilepsy	☐ Adopted	

Has the patient reached puberty?

Girls: Has she started menstruation Yes ☐ No ☐ If yes, Month/Year _____

Boys: Has his voice changed: Yes ☐ No ☐ If yes, Month/Year _____

Please complete the following information as accurately as possible to help us evaluate family growth pattern:

Father: Height _____ Mother: Height _____ Patient: Height _____ Weight _____

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? _____ ☐ Yes ☐ No

Has the patient ever sucked a thumb or fingers? _____ ☐ Yes ☐ No

Until what age? _____

Has an orthodontist been consulted previously? _____ ☐ Yes ☐ No

Has the patient had any previous orthodontic treatment? _____ ☐ Yes ☐ No

If so, by whom? _____

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

Has either parent had orthodontic treatment? _____ ☐ Yes ☐ No

Please list any family members treated here _____

What part of your child's orthodontic problem concerns you most? _____

Additional information which you feel would help make your child's association with us more enjoyable _____

Member
American Association of
Orthodontists

THANK YOU

_____

SIGNATURE OF PARENT OR GUARDIAN