



JACK "CHIP" CASE JR., DDS, MS

Diplomate American Board of Orthodontics

"The right place for orthodontic treatment. Healthy smiles for the whole family"

PATIENT ACQUAINTANCE FORM

Date: \_\_\_\_\_

Patient # \_\_\_\_\_

(office use only)

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 \_\_\_\_\_ (Last First Middle) Marital Status \_\_\_\_\_

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 \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ (Last First Middle) Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

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

Other Parent's Name \_\_\_\_\_ (Last First Middle) Employer \_\_\_\_\_

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

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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: \_\_\_\_/\_\_\_\_/\_\_\_\_