

RANDALL P. RIGSBY, D.M.D.

Welcome To Our Office

ORTHODONTIC ACQUAINTANCE CARD

DATE _____

—Please Print—

Patient's Name _____ Date of Birth _____
Age _____ Sex: Male Female

Name Patient Prefers to be Called _____ Telephone Number _____

Home Address _____ Zip Code _____

School _____ Grade _____ Last Visit to Dentist _____

Patient's Hobbies or Interests _____ Name of Dentist _____

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 _____

Parent's Marital Status Married Divorced Separated Single Widowed

Names and Ages of Other Children in Family _____

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

Name of Insurance Company _____

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

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

List any medicines your child is currently taking _____

List any drug sensitivities _____

Is there a history of serious illness, accident or operation? _____

If so, list _____

PLEASE CHECK THE FOLLOWING:

- | | | | |
|--|--|--|---|
| Yes/No | Yes/No | Yes/No | Yes/No |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head or Facial Injury | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Aids |
| | | | <input type="checkbox"/> Adopted |

Has the patient reached puberty? _____

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

Boys: Secondary Sex Characteristics: Hair Development? Yes No Has voice changed? Yes No

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 tooth? _____ 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 previously 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 _____

