LEWISBURG ORTHODONTIC ASSOCIATES
CHILD ORTHODONTIC ACQUAINTANCE CARD

Date:_____ Birthdate: _____
Patient's Name: _____ Age: _____ Gender: _____
Nickname / what do you prefer to be called? _____
Address: _____

Dentist: _____ Physician: _____
Referred by: _____

Parent/legal guardian
Name: _____ DOB: _____
Address: _____
Cell phone: _____ Secondary phone: _____
Email: _____
Employer: _____ Occupation: _____

Parent/legal guardian
Name: _____ DOB: _____
Address: _____
Cell phone: _____ Secondary phone: _____
Email: _____
Employer: _____ Occupation: _____

Parents' marital status: Married Divorced Separated Unmarried

Name and ages of other children in the family: _____
_____

Who is responsible for payment of account? _____

Orthodontic insurance coverage? Yes / No

For HIPAA purposes: Please list any additional adults who can receive information regarding your child.

Name	Relationship	Treatment information	Financial information
_____	_____	Yes / No	Yes / No
_____	_____	Yes / No	Yes / No
_____	_____	Yes / No	Yes / No
_____	_____	Yes / No	Yes / No

Parent's signature: _____ Date: _____

CHILD MEDICAL HISTORY

Please read carefully – answer each question accurately

1. Is your child in good health? Yes / No _____

2. Does your child have any history of major illnesses? Please list.

_____

3. Please circle any of the following which your child has had, past or present:

Pneumonia	Seizures	Gland problems	Cold sores
Asthma	Epilepsy	Unexplained weight loss	Venereal disease/STD
Hay fever	Anemia	Swollen ankles	Glaucoma
Shortness of breath	Hemophilia	Endocrine problems	Hearing impaired
Emphysema	Bleeding disorders	Thyroid disease	Cancer
Dizzy spells	Prolonged bleeding	Diabetes	Chemotherapy
Tuberculosis (TB)	Bruises easily	Ulcer	Radiation therapy
Heart condition	Blood transfusion	GERD/acid reflux	Emotional/depression
Heart murmur	Autoimmune disorder	AIDS/HIV positive	Eating disorder
Heart valve	Celiac or shellfish allergy	Kidney trouble	ADHD/ADD
Chest pain	Bone disorders	Liver disease	Autism Spectrum Disorder
Stroke	Oral/IV bisphosphonates	Jaundice	Congenital disease/genetic
High blood pressure	Arthritis	Hepatitis	disorder or syndrome
Migraines	Artificial joints/implants	Rheumatic fever	

Please explain any of the above issues and any additional conditions not mentioned above:

_____

_____

5. Is your child presently, or have they been under a physician's care during the past year? Yes / No
If yes, please explain: _____

6. Is your child currently on any medications? Yes / No
Please list: _____

7. Does your child have a latex allergy? Yes/No
Does your child have any allergies to medications or other materials? Yes / No
Please list: _____

8. Has your child ever had a reaction to a local anesthetic? Yes / No
If yes, please explain: _____

9. Has your child ever experienced any complication following a dental procedure? Yes / No
If yes, please explain: _____

10. Does your child require antibiotics prior to dental procedures? Yes / No

11. Has your child ever been told they were not eligible to be a blood donor? Yes / No
If yes, please explain: _____

12. Does your child use tobacco (smoke, smokeless, vape)? Yes / No
Alcohol use? Yes/No Illegal drug use? Yes/No

13. Is your child pregnant or do you think she may be pregnant? Yes / No

Any other pertinent medical information?

_____

_____

Parent's signature _____ Date: _____

DENTAL HISTORY

YOUR MAIN REASONS FOR THIS CONSULTATION _____

_____

LAST DENTAL CLEANING? (month, year) _____

Any future dental procedures being planned or discussed (extractions, implants, restorations, etc.)

_____

ANY PREVIOUS INJURIES TO HEAD, FACE, MOUTH, TEETH? YES NO
Brief description and date of injury _____

HISTORY OF THUMB OR FINGERSUCKING? (Until what age? _____) YES NO

SPEECH PROBLEMS? YES NO

DIFFICULTY WITH CHEWING OR SWALLOWING? YES NO

HISTORY OF CLENCHING, GRINDING OR JAW JOINT PAIN? YES NO

HAVE ANY PERMANENT TEETH BEEN REMOVED? YES NO

When and for what reason? _____

HAVE YOU BEEN INFORMED OF ANY CONGENITALLY MISSING TEETH? YES NO

HAVE YOU BEEN INFORMED OF ANY EXTRA TEETH PRESENT? YES NO

ANY PREVIOUS ORTHODONTIC TREATMENT? YES NO

Full braces? retainers? other treatment? _____

HAS THERE BEEN A PRIOR ORTHODONTIC CONSULTATION? YES NO

OTHER INFORMATION YOU FEEL IS PERTINENT _____

_____

_____