



2000 NE 44th Street . Suite #201
Lighthouse Point, FL 33064

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Coral Springs, FL 33067

www.wileysmiles.com

ORTHODONTIC ACQUAINTANCE CARD
(PLEASE COMPLETE AND BRING TO APPOINTMENT)

GENERAL INFORMATION

	Last	First	M.I.	
1.	FULL Name _____			Soc. Sec. # _____
2.	Home Address _____			Phone # _____
3.	City, State, Zip _____			D.O.B. _____
4.	Place of Employment _____			Occupation _____
5.	Address _____			6. Phone # _____
7.	SPOUSE'S FULL Name _____			Soc. Sec. # _____
8.	Home Address _____			
9.	Place of Employment _____			Occupation _____
10.	Occupation _____			
11.	Address _____			12. Phone _____
13.	Marital Status Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>			
14.	Person Responsible for Account _____			Soc. Sec. # _____
15.	Address _____			Phone _____
16.	Do you have insurance which includes orthodontic treatment Yes <input type="checkbox"/> No <input type="checkbox"/> What company? _____			
17.	Do you frequently participate in contact sports? _____			
18.	What are your main extracurricular activities or interests? _____			
19.	Play a musical instrument? _____ If yes, please name _____			
20.	Patient's Dentist _____			Phone # _____
	Patient's Physician _____			Phone # _____
21.	Children of Patient		Name _____	Date of Birth _____
			Name _____	Date of Birth _____
			Name _____	Date of Birth _____
			Name _____	Date of Birth _____
			Name _____	Date of Birth _____
22.	Who referred you to this office? _____			
	Area or address (if available): _____			
23.	Name of close friends or relatives that are patients of this practice _____			

24.	Name of nearest relative _____			Relationship _____
	Address _____			Phone _____

(OVER)

1. **MEDICAL HISTORY.** Circle the correct response in the appropriate box indicating whether or not you currently have, previously had any of the following conditions.

Never Had Previous Condition Current Condition

- N Y Y Anemia
- N Y Y Asthma
- N Y Y Diabetes
- N Y Y Thyroid
- N Y Y Kidney Disease
- N Y Y Jaundice
- N Y Y Osteomyelitis
- N Y Y Rheumatic Fever
- N Y Y Tuberculosis
- N Y Y Frequent Sore Throats
- N Y Y Frequent Colds
- N Y Y Heart Conditions

Never Had Previous Condition Current Condition

- N Y Y Epilepsy (convulsions)
- N Y Y Allergies
- N Y Y Fainting Spells
- N Y Y Frequent Headaches
- N Y Y Hemophilia (bleeder)
- N Y Y Intestinal Upsets
- N Y Y Vitamin Deficiency
- N Y Y Sinus Problems
- N Y Y Rheumatism
- N Y Y Tonsils Removed
- N Y Y Andenoids Removed
- N Y Y Hepatitis

Never Had Previous Condition Current Condition

- N Y Y Chicken Pox
- N Y Y Diphtheria
- N Y Y Ear Ache
- N Y Y Influenza
- N Y Y Measles
- N Y Y Mumps
- N Y Y Pneumonia
- N Y Y Scarlet Fever
- N Y Y Whooping Cough
- N Y Y Frequent Bronchitis
- N Y Y Eczema
- N Y Y Rickets
- N Y Y Aids/HIV +

2. Other disease not listed _____

3. Chronic ailments, if any _____

4. Operations _____ 5. Accidents _____

6. What x-rays have been taken in the last year? Medical as well as dental _____

Y N Are you allergic to any medications? Foods, anything? describe _____

Y N Are you under psychological guidance? (Now or previously) _____

If yes, for what condition? _____

7. List drugs or medications now being taken and give reasons? _____

8. **DENTAL HISTORY**

Y N Have you ever sucked a finger, cheek, etc.? Until what age? _____

Y N Did you ever bite nails, pencils, etc. Until what age? _____

Y N Do you have any other unusual habits? List _____

Y N Do you have speech problems? Explain _____

Y N Are you a mouth breather? While awake or asleep?

Y N Any injuries to the face, mouth or teeth?

Y N Tooth clenching or grinding at night?

Y N Any injuries to the teeth?

Y N Accident or trauma to the head?

Y N Accident or trauma to the face?

Y N Accident or trauma to the jaw?

Y N Whiplash neck injury?

Y N Cervical traction neck collar?

Y N Received severe blow to side of head or jaw?

9. When was your last dental check-up? _____

10. What is your orthodontic problem, as you see it? _____

SIGNATURE OF INDIVIDUAL FILLING IN THIS FORM _____

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Thank You

