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

4689 N. University Drive
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☐ Divorced☐ Separated☐ Widowed☐
14. Person Responsible for Account ______________________ Soc. Sec. #______________
15. Address ______________________ Phone ______________
16. Do you have insurance which includes orthodontic treatment Yes ☐ No ☐ 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		Never Had	Previous Condition	Current Condition		Never Had	Previous Condition	Current Condition	
N ☐	Y ☐	Y ☐	Anemia	N ☐	Y ☐	Y ☐	Epilepsy (convulsions)	N ☐	Y ☐	Y ☐	Chicken Pox
N ☐	Y ☐	Y ☐	Asthma	N ☐	Y ☐	Y ☐	Allergies	N ☐	Y ☐	Y ☐	Diptheria
N ☐	Y ☐	Y ☐	Diabetes	N ☐	Y ☐	Y ☐	Fainting Spells	N ☐	Y ☐	Y ☐	Ear Ache
N ☐	Y ☐	Y ☐	Thyroid	N ☐	Y ☐	Y ☐	Frequent Headaches	N ☐	Y ☐	Y ☐	Influenza
N ☐	Y ☐	Y ☐	Kidney Disease	N ☐	Y ☐	Y ☐	Hemophilia (bleeder)	N ☐	Y ☐	Y ☐	Measles
N ☐	Y ☐	Y ☐	Jaundice	N ☐	Y ☐	Y ☐	Intestinal Upsets	N ☐	Y ☐	Y ☐	Mumps
N ☐	Y ☐	Y ☐	Osteomyelitis	N ☐	Y ☐	Y ☐	Vitamin Deficiency	N ☐	Y ☐	Y ☐	Pneumonia
N ☐	Y ☐	Y ☐	Rheumatic Fever	N ☐	Y ☐	Y ☐	Sinus Problems	N ☐	Y ☐	Y ☐	Scarlet Fever
N ☐	Y ☐	Y ☐	Tuberculosis	N ☐	Y ☐	Y ☐	Rheumatism	N ☐	Y ☐	Y ☐	Whooping Cough
N ☐	Y ☐	Y ☐	Frequent Sore Throats	N ☐	Y ☐	Y ☐	Tonsils Removed	N ☐	Y ☐	Y ☐	Frequent Bronchitis
N ☐	Y ☐	Y ☐	Frequent Colds	N ☐	Y ☐	Y ☐	Andenoids Removed	N ☐	Y ☐	Y ☐	Eczema
N ☐	Y ☐	Y ☐	Heart Conditions	N ☐	Y ☐	Y ☐	Hepatitis	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?

Y☐ N☐ Did your jaw ever lock open or closed following a lengthy dental procedure?

Y☐ N☐ Is there any discomfort when you open or close your mouth?

Y☐ N☐ Any clicking or pain when you open or close your mouth?

Y☐ N☐ Broken jaw?

Y☐ N☐ Experienced a fall?

Y☐ N☐ Has other family member had orthodontic treatment?

Y☐ N☐ Has orthodontist been consulted previously?

Y☐ N☐ If yes, name of orthodontist ____________

Address ____________

When was the evaluation? ____________

Y☐ N☐ Were diagnostic records taken?

What treatment was recommended? ____________

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 ________________________

(PLEASE COMPLETE AND BRING TO APPOINTMENT)

Thank You