John M. Wirant, D.M.D.
ORTHODONTICS

ORTHODONTIC ACQUAINTANCE FORM

Patient's Name:			Date:
Last	First	M.I.	Date Of Birth:
Home Address:			Sex:
			Home phone:
School:			Cell:
City:	Zip:	Grade:	SS#:
Father's Name:		Occupation:	
Employed By:			Father's Cell:
Business Address:			Zip:
Mother's Name:		Occupation:	
Employed By:			Mother's Cell:
Business Address:			Zip:

Who does the child reside with: Mother Father Both Parents Other:

Address of non-custodial parent (if applicable):

Names and Ages of other children in family:

Email address for appointment reminders:

Medical History

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Name of your child's physician:

Is your child in good health? Yes No

Has your child ever been hospitalized, had general anesthesia of emergency room visits? Yes No Don't Know

If yes, please explain:

Are your child's immunizations up to date? Yes No Don't Know

Allergies (please list):

Past medications taken by child:

Daily medications child is now taking:

Has your child ever had or been treated by a physician for:

Problems at birth	Tuberculosis	Cleft lip/palate	Heart murmur	Liver disease
Speech/Hearing problems	Eye problems	Heart disease	Kidney disease	Rheumatic fever
Diabetes	Skin problems	Anemia	Arthritis	Tonsil/Adenoid problems
Bleeding/hemophilia	Cancer	Sleep problems	Blood Transfusion	Cerebral palsy
Emotional/behavioral issues	Hepititis	Seizures	AIDS/HIV	Asthma

Other Please list:

GIRLS -started menstration *BOYS* - voice changed Yes No Height Weight

Do you consider your child to be (check one): Advanced in learning Progressing normally Slow learner

Dental History

What is your main concern about your child's dental condition?

Last dental exam date:

Name of your child's dentist: City/Town

Yes	No	??	Has your child had dental x-rays? Date of last x-rays:
Yes	No	??	Will your child be uncooperative? If yes, please expain:
Yes	No	??	Has your child experienced any complications following dental treatment? If yes, please explain:
Yes	No	??	Has your child had cavities and toothaches?
Yes	No	??	Are your child's teeth sensitve to temperature, pressure or certain foods?
Yes	No	??	Have you or your child ever received instruction on proper tooth brushing technique?
Yes	No	??	Do your child's gums bleed when brushed?
Yes	No	??	Does your child use fluoride products, rinses, drops, or tabs?
Yes	No	??	Has your child had any clicking or pain in his/her jaw joints? If yes , please explain:
Yes	No	??	Has your child inherited any family facial of dental characteriseristics? If yes, please explain:
Yes	No	??	Is your child a mouth breather? While Awake? While Asleep?
Yes	No	??	Has your child ever injured his/her teeth?
Yes	No	??	Has your child ever injured his/her jaw or face?
Yes	No	??	Have you been informed of any missing or permanent teeth?
Yes	No	??	Did your child use a pacifier?
Yes	No	??	Did your child suck his/her finger or thumb? Until what age?
Yes	No	??	Has another orthodontist been consulted previously?
Yes	No	??	Has either parent had orthodontic treatment?
Yes	No	??	List any instruments played:

Does your child have any other dental problems we should know about? Yes No Please explain:

How did you hear about us?

Whom may we thank for referring you to our office?

How else did you hear about us? Check all that apply.

Mailer/postcard Sign Website Google search Insurance

Doctor's office Event Facebook Other:

PERSON COMPLETING THIS FORM:

Signature:

Relationship to patient :

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