

### Orthodontic Acquaintance Information

*(Please print)*

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age Yrs. \_\_\_\_\_ Months \_\_\_\_\_ Sex \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Main concern \_\_\_\_\_

Your General Dentist \_\_\_\_\_

	Yes	No
Does the patient have regular dental treatment?.....	_____	_____
Date of last complete dental exam _____		
Has the patient ever had any abscessed teeth?.....	_____	_____
Does the patient have any cavities that need attention? .....	_____	_____
Has the patient had his/her teeth cleaned in the last three months? Fluoride treatment? .....	_____	_____
Have there been any injuries to the face, mouth, teeth or scars? When _____	_____	_____
Has the patient ever sucked a thumb or finger (until what age? _____).....	_____	_____
Does the patient have (or had) any speech problems?.....	_____	_____
Have tonsils and adenoids been removed? If so, when _____	_____	_____
Does the patient breathe predominantly through the mouth? .....	_____	_____
Were any teeth (baby or permanent) removed at any time by a Dentist? (Which teeth _____ Age _____).....	_____	_____
Does the patient grind or clench his/her teeth? At night? .....	_____	_____
Does the patient have clicking, popping, and/or pain upon closing the mouth? .....	_____	_____
Have you been informed of any missing permanent teeth? .....	_____	_____
Have you been informed of any extra permanent teeth? .....	_____	_____
Has an orthodontist been consulted previously?.....	_____	_____
Does anyone in the family have similar dental/orthodontic conditions? .....	_____	_____
Did they have any orthodontic treatment? .....	_____	_____
Is patient adopted or foster? .....	_____	_____
Does the patient desire orthodontic treatment? .....	_____	_____
List any wind instruments played, or planned to play. _____		
Who first noticed the need for orthodontic treatment? General dentist _____ Parent _____ Patient _____ When? _____		
Have any appliances been placed in the patient's mouth to maintain space? .....	_____	_____
Are you aware that some appointments will infringe on school time? or work? .....	_____	_____
Other relevant information you feel Dr. Strickland should be aware of. _____		
_____		
_____		
_____		

