HUMBERTOWN ORTHODONTICS

Dr. Harold Rosenberg
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Certified Specialist in Orthodontics and Dentofacial Orthopedics

Child Orthodontic Acquaintance Form

Patient Name:

Who may we thank for referring you? _____

Mother's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Father's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home

Contact e-mail: _____ Person responsible for account:_____

Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure

MEDICAL HISTORY - HAS THE CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Disease	□ Yes □ No	Sexually Transmitted Diseases	□ Yes □ No	Asthma	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Blood Pressure	□ Yes □ No	Arthritis	□ Yes □ No
Artificial Joints	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	Other _____	
ADHD/ ADD	□ Yes □ No	Epilepsy/ Seizures	□ Yes □ No		

If you responded YES to any of the above questions, please give pertinent information: _____

_____

Is the child in good health? _____

List any drugs or medications now being taken: Please give reasons: _____

Does the child have any history of major illness and/or operations? _____

List any allergies or drug sensitivities: _____

Have tonsils or adenoids been removed? □ Yes □ No At what age? _____

DENTAL HISTORY

Has the child ever been treated for a jaw joint problem, including surgery?		□ Yes □ No		
Have there been any injuries to the face, mouth or teeth?		□ Yes □ No	Please describe:	_____
Has the child ever sucked his/her thumb or finger?		□ Yes □ No	Until what age?	_____
Does the child have any speech problems?		□ Yes □ No		
Does the child have frequent canker or cold sores?		□ Yes □ No		
Is the child a mouth breather?	While Asleep:	□ Yes □ No	While Awake:	□ Yes □ No
Have you been informed of any missing or extra permanent teeth?		□ Yes □ No		
Has the child ever had a previous orthodontic examination?		□ Yes □ No		
Is the child especially apprehensive towards dental visits?		□ Yes □ No		
Does the child want orthodontic treatment?		□ Yes □ No		
Has any other family member had braces or orthodontic treatment?		□ Yes □ No		

Please name the family member if treated in our office: _____

When did the child last see the family dentist? _____

List any sports, hobbies or musical instruments played: _____

Reason for orthodontic consultation: _____

I hereby give Dr. Harold Rosenberg and/or members of his staff permission to release information concerning me or my child's dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment or treatment in progress.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____

Signature of Parent or Legal Guardian Date