KEITH T. SELLERS, D.D.S., M.S.

Welcome to our Office

Orthodontic Acquaintance Form

Patient Information **Date:**

Acct.#: _____ Patient Name: _____ Nickname: _____

Address: _____
Street City State Zip

Home Phone: _____ Hobbies: _____ School: _____

Age: _____ Birthdate: _____ General Dentist: _____

Responsible Party Information

Father _____ SS# _____ Mother _____ SS# _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Employer _____ Work # _____ Employer _____ Work # _____

Do you have Orthodontic Insurance? ☐ Yes ☐ No

Name and ages of children or other siblings _____

Whom may we thank for referring you to our office? Dentist _____ Patient/Friend _____

MEDICAL HISTORY

Physician's Name _____ Date of last physical exam _____

Is patient in good health? Yes ☐ No ☐

Has patient ever been under the care of a physician for illness? Yes ☐ No ☐

Please list _____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED.

Glaucoma ☐	Epilepsy ☐	High Blood Pressure ☐
Diabetes ☐	Asthma ☐	Low Blood Pressure ☐
Pneumonia ☐	Kidney Involvement ☐	Circulatory Problems ☐
Heart Trouble ☐	Endocrine Problems ☐	Radiation Treatment ☐
Rheumatic Fever ☐	Prolonged Bleeding ☐	Arthritis ☐
Bone Disorders ☐	Fainting or Dizziness ☐	Hepatitis ☐
Tuberculosis ☐	Nervous Disorders ☐	Malignancies ☐
Anemia ☐	Liver Involvement ☐	HIV/Aids ☐

Does the patient have tendency to colds? ☐ Sore Throats ☐ Ear Infections ☐

Have tonsils and adenoids been removed? What age? _____ Yes ☐ No ☐

Is patient pregnant? Yes ☐ No ☐

List any allergies or medications now being taken. Give reasons: _____

Latex allergic? Yes ☐ No ☐

DENTAL HISTORY

Have there ever been any injuries to the face, mouth, or teeth? Yes ☐ No ☐ _____

Has patient ever sucked their fingers or thumb? Until what age? Yes ☐ No ☐ _____

Does patient have any speech problems? Yes ☐ No ☐ _____

Is patient a mouth breather? While awake? Yes ☐ No ☐ _____

While asleep? Yes ☐ No ☐ _____

Has patient ever been informed of any missing or extra permanent teeth? Yes ☐ No ☐ _____

Has patient ever consulted or been treated by an orthodontist previously? Yes ☐ No ☐ _____

Did either parent have orthodontic treatment? Yes ☐ No ☐ _____

Does patient have pain the jaw joints? Right ☐ Left ☐ Does patient have popping or cracking of the jaw joints? Right ☐ Left ☐

When did this begin? _____

Patient's attitude toward orthodontic treatment: wants treatment treatment if necessary unwilling but agrees uncooperative

I understand that where appropriate, credit bureau reports may be obtained.

Responsible Party Signature _____