INNA GELLERMAN, D.D.S.

ORTHODONTIC ACQUAINTANCE CARD

Date ________/________/________

Patient's Name ____ Date of Birth _________/_________/_________

Last *First* *MI.*

Res. Address ____________________ Apt.#________________ Age ______________ Sex __________ Height __________ Weight___________

City ____Zip ____________ Telephone ____________________________________

School____State____

Summer Camp if Applicable______________________________Grade __________ Summer Telephone ___________________________

Referred By ____ E-Mail ____

Patient's Dentist ____________________________________Address____

Pediatrician ____Oral Surgeon ____

Father's Name_______________________________________Occupation____

Employed By ________________________________ Bus. Telephone ____________________________________

Bus. Address ________________________________Father's Dentist ____________________________________

Mother's Name ______________________________________ Occupation ____

Employed By ________________________________ Bus. Telephone ____________________________________

Bus. Address ________________________________Mother's Dentist ____________________________________

Person assuming financial responsibility ____

Address ____Apt.# _________ City & State ______________________________

Insurance coverage .... Yes No

Primary Insurance Co. ________________________________ Policy No.____

Secondary Insurance Co._______________________________Policy No.____

Names and ages of other children in family____

Person to contact in case of emergency____

____ Telephone ____

Reason for consultation ____

____

MEDICAL HISTORY

Is patient in good health? .... Yes No

Does patient have any history of major illness? .... Yes No

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

Has patient ever been hospitalized?... Yes No

Please explain ____

Date of last examination by physician ____

Does patient bruise easily? .... Yes No

Has patient ever required a blood transfusion? .... Yes No

Does patient have tendency to colds? .... Yes No

sore throats? .... Yes No

Have tonsils and/ or adenoids been removed? .... Yes No

If yes, at what age? ____

Does patient have chronic ear pain or infections? .... Yes No

Does patient take sedatives, tranquilizers, sleeping pills or medicine to relax? .... Yes No

Does patient have trouble sleeping? .... Yes No

Does patient snore when sleeping? .... Yes No

List any drugs or medications now or previously taken: ____

Please indicate yes or no for any condition patient has experienced:

Condition			Condition		
Heart murmur	Yes	No	Sinus trouble	Yes	No
Rheumatic fever	Yes	No	Epilepsy	Yes	No
High blood pressure	Yes	No	Fainting	Yes	No
Low blood pressure	Yes	No	Arthritis	Yes	No
Hepatitis	Yes	No	Anemia / blood disease	Yes	No
Diabetes	Yes	No	Tumors / growths	Yes	No
Kidney disease	Yes	No	Thyroid / parathyroid problems	Yes	No
Asthma	Yes	No	Bone disorders	Yes	No
Tuberculosis	Yes	No	Seizures	Yes	No
Pneumonia	Yes	No	Endocrine problems	Yes	No
Often fatigued / exhausted	Yes	No	Frequent headaches	Yes	No
Nervous / anxious	Yes	No	Immune system problems	Yes	No
Any recent weight gain / loss	Yes	No	Psychiatric care	Yes	No
Cancer treatment	Yes	No	Prolonged bleeding	Yes	No

Is patient allergic or have reacted adversely to:

Local anesthetics .... Yes No

Penicillin / other .... Yes No

Sulfa drugs? .... Yes No

Barbiturates, sedatives or sleeping pills .... Yes No

Aspirin .... Yes No

Iodine .... Yes No

Codeine or other narcotics .... Yes No

Other ______________________________

DENTAL HISTORY

Date of patient's last dental examination or treatment ______________________________

Has patient had any serious problems associated with previous dental treatment? .... Yes No

Has there been any injuries to your face, mouth or teeth? .... Yes No

Has there been any treatment for problems of your jaw joint or for facial muscle spasms? .... Yes No

Has the patient ever sucked a thumb or fingers? .... Yes No

Until what age? ______________________________

Does the patient have any speech problems? .... Yes No

Is the patient a mouth breather? .... Yes No

At what times? ______________________________

Have you been informed of any missing or extra teeth? .... Yes No

Does food catch or collect between teeth? .... Yes No

Does the patient clench or grind their teeth? .... Yes No

Is there clicking, popping or grating noise from the patient's jaw when chewing? .... Yes No

Is there numbness or tingling associated with the patient's mouth or face? .... Yes No

Has the patient ever had orthodontic treatment or been treated for a bad bite? .... Yes No

Has an orthodontist been consulted previously? .... Yes No

Has the patient ever had periodontal (gum) disease? .... Yes No

Has either parent had orthodontic treatment? .... Yes No

Has either parent had periodontal disease? .... Yes No

Does the patient use a mouthguard during sports? .... Yes No

List any musical instruments played: ______________________________

Parent Signature ______________________________