Rodney J. Klima, D.D.S., P.C.
Child Orthodontic Acquaintance Card

Date: ____________ (Month / Day / Year) Date Of Birth: ____________ (Month / Day / Year) Patient Age: ______

Patient Name: ____________ Name Patient Goes By: ____________ Gender: M F

Home Address: ____________ (Street Address / City / State / Zip)

Home Phone: ________ Cell Phone: ________ School: ____________ Grade: ______

Referred By: ____________ Have you seen another orthodontist: ☐ Yes ☐No

Patient's Dentist: ____________ Patient's Physician: ____________

Father's Name: ____________ Occupation: ____________

Employed By: ____________ S.S.# ________ Bus. Phone: ( ) ________

Address if different from Patient: ____________ (Street Address / City / State / Zip)

Home Phone: ( ) ________ Cell Phone: ( ) ________

Mother's Name: ____________ Occupation: ____________

Employed By: ____________ S.S.# ________ Bus. Phone: ( ) ________

Address if different from Patient: ____________ (Street Address / City / State / Zip)

Home Phone: ( ) ________ Cell Phone: ( ) ________

Person or Persons responsible for account: ____________

Address if different from Patient: ____________ (Street Address / City / State / Zip)

Dental Insurance Carrier: ____________ Orthodontic Coverage: ☐ Yes ☐No ☐Unsure

Policyholder Name: ________ ID# ________ Policyholder DOB: ________

General Appraisal

What concerns you most about your child's teeth? ____________

Names and ages of your other children with similar orthodontic problems: ____________

Parents or grandparents with similar problems: ____________

Has any member of your family received orthodontic treatment? ____________

Will patient's cooperation be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Indifferent

Patient's attitude toward receiving orthodontic treatment: ____________

Have we seen any other members of your family? ☐ Yes ☐No Name: ____________ Age: ______

Medical History

Is patient in good health? ☐ Yes ☐No If No, explain: ____________

Does the patient have any history of major illness? ☐ Yes ☐No If Yes, explain: ____________

Check any of the following for which the patient has been diagnosed or treated:

- ☐ ADD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Bone Disorders
- ☐ Bleeding Abnormality
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Hepatitis, Type:____
- ☐ Kidney Involvement
- ☐ Learning Disability
- ☐ Liver Involvement
- ☐ Nervous Disorder
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other: ____________

Does patient have a tendency to: ☐ Colds ☐ Sore Throats: ☐ Ear Infections:

Have the patient's tonsils or adenoids been removed? ☐ Yes ☐No If yes, at what age: ______

List any drugs or medications now being taken by the patient with reason for taking it: ____________

List any allergies or drug sensitivity: ____________

Has the patient reached puberty? ☐ Yes ☐No Girls: Has she started menstruation? ☐ Yes ☐No Boys: Has his voice changed? ☐ Yes ☐No

Dental History

Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐No If Yes, explain: ____________

Has the patient ever sucked a thumb or fingers? ☐ Yes ☐No Until what age? ______ Habit Continues? ☐ Yes ☐No

Does the patient have speech problems? ☐ Yes ☐No If Yes, explain: ____________

Is the patient a mouth breather? While Awake? ☐ Yes ☐No While asleep? ☐ Yes ☐No

Have you been informed the patient has any missing or extra teeth? ☐ Yes ☐No

List any musical instruments the patient plays: ____________

Responsible Party/Parent
Email Address: ____________ (Print Clearly)

____
Signature of Parent or Guardian

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