

**ACQUAINTANCE FORM**

Today's Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Patient's Brothers/Sisters and Ages \_\_\_\_\_

Patient's under age 10: favorite pet, friend or toy: \_\_\_\_\_

Father or Guardian's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Position \_\_\_\_\_ Years \_\_\_\_\_

Work Phone \_\_\_\_\_ Extension \_\_\_\_\_

Mother or Guardian's Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Position \_\_\_\_\_ Years \_\_\_\_\_

Work Phone \_\_\_\_\_ Extension \_\_\_\_\_

If no telephone, please give a number for where we can leave a message:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Person responsible for financial obligation? \_\_\_\_\_

Insurance: Dental Care? \_\_\_\_\_ Orthodontic? \_\_\_\_\_

Name of Insurance Co.? \_\_\_\_\_ ID # \_\_\_\_\_

Who referred you to our practice? \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Is your child taking any medication now? \_\_\_\_\_ What? \_\_\_\_\_

Has your child been hospitalized? \_\_\_\_\_ When? \_\_\_\_\_ Why? \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ What? \_\_\_\_\_

Has your child had any unusual reaction to any of these drugs?

YES	NO		YES	NO		YES	NO	
___	___	Aspirin	___	___	Penicillin	___	___	Codeine
___	___	Tylenol	___	___	Other Antibiotics	___	___	Local Dental Anesthesia
___	___	Nitrous Oxide	___	___	Valium	___	___	Latex Allergy
___	___	Chloral Hydrate	___	___	Seconal	___	___	Other

Has your child ever had any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Anemia	___	___	Fainting	___	___	Pneumonia
___	___	Arthritis	___	___	Heart Trouble	___	___	Prolonged Bleeding
___	___	Asthma	___	___	Hepatitis	___	___	Rheumatic Fever
___	___	Blood Pressure	___	___	HIV/AIDS	___	___	Severe Infections
___	___	Convulsions/Epilepsy	___	___	ADD/ADHD	___	___	Tuberculosis
___	___	Diabetes	___	___	Liver Disease	___	___	Other

Does your child have any psychological or emotional problems that you feel should be brought to our attention? \_\_\_\_\_

Has your child ever had experiences with other health professionals which have been unpleasant? \_\_\_\_\_

Any other information which you consider important: \_\_\_\_\_

## DENTAL HISTORY

1. Previous Dental Experience: (If 1st visit please check  and skip to Section 2)

- A. Name of last dentist \_\_\_\_\_
- B. Date of last visit \_\_\_\_\_ Was treatment completed? \_\_\_\_\_
- C. Was the experience pleasant? \_\_\_\_\_
- D. Were x-rays taken? \_\_\_\_\_ Date \_\_\_\_\_ Number \_\_\_\_\_
- E. Has your child seen an orthodontist? \_\_\_\_\_
- F. Has anyone in your family had orthodontic treatment? \_\_\_\_\_

2. Current Oral Health Habits:

- A. Does your child receive fluoride in any of the following forms?  
Water \_\_\_\_\_ Toothpaste \_\_\_\_\_ Vitamin drops \_\_\_\_\_ Tablets \_\_\_\_\_ Rinses \_\_\_\_\_ Other \_\_\_\_\_
- B. Brushing:
  - 1. Toothbrush: soft \_\_\_\_\_ medium \_\_\_\_\_ hard \_\_\_\_\_; Frequency per day: \_\_\_\_\_
  - 2. Do you assist your child? \_\_\_\_\_; How often? \_\_\_\_\_
  - 3. Does your child floss? \_\_\_\_\_; How often? \_\_\_\_\_
- C. Snack foods? \_\_\_\_\_ Please list \_\_\_\_\_
- D. Has your child ever taken a bottle to bed? \_\_\_\_\_ Contents? \_\_\_\_\_

3. Current Oral Conditions:

- A. Does your child suck his/her thumb, fingers or blankets? \_\_\_\_\_
- B. Has your child experienced any cold sores in or around his/her mouth? \_\_\_\_\_
- C. Does your child have any speech problems? \_\_\_\_\_
- D. Do you feel your child may have:
  - 1. Cavities? \_\_\_\_\_
  - 2. Gum disease? \_\_\_\_\_
  - 3. Crooked teeth (malocclusion)? \_\_\_\_\_
  - 4. Other \_\_\_\_\_
- E. Do you desire complete dental care for your child? \_\_\_\_\_  
If not, with what specific problems would you like us to help? \_\_\_\_\_

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## AUTHORIZATION

*I hereby give permission to Dr. James B. King, Dr. Mark E. Wohlfeld and their staff to give emergency, diagnostic and routine care to my child \_\_\_\_\_ I understand the procedures, alternatives and the risks involved. I authorize the use of dental radiographs, local anesthesia and other medications deemed necessary or helpful in completing the treatment. I understand that I or another responsible adult should always accompany my child for care. My signature in no way gives up any of my rights or re leases the dentist from responsibility.*

*Parent or Guardian* \_\_\_\_\_ *Date* \_\_\_\_\_