

# Nadia Laniado, D.D.S.

## CHILD'S ORTHODONTIC ACQUAINTANCE FORM

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

Date of Birth \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle Age Sex

Nickname \_\_\_\_\_

Resident Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Referred By \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Pediatrician \_\_\_\_\_

Name and Address of Party Responsible for Payment \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed By \_\_\_\_\_ Business Telephone \_\_\_\_\_

Business Address \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed By \_\_\_\_\_ Business Telephone \_\_\_\_\_

Business Address \_\_\_\_\_

Name and ages of other children in family \_\_\_\_\_

Favorite sports, hobbies \_\_\_\_\_

### MEDICAL HISTORY

Is patient in good health? \_\_\_\_\_ Yes  No

Does patient have any history of major illness? \_\_\_\_\_ Yes  No

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

Please list \_\_\_\_\_

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

- |                       |                          |                          |                          |                             |                          |
|-----------------------|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|
| Diabetes .....        | <input type="checkbox"/> | Tuberculosis .....       | <input type="checkbox"/> | Endocrine Problems .....    | <input type="checkbox"/> |
| Pneumonia .....       | <input type="checkbox"/> | Anemia .....             | <input type="checkbox"/> | Prolonged Bleeding .....    | <input type="checkbox"/> |
| Heart Trouble .....   | <input type="checkbox"/> | Epilepsy .....           | <input type="checkbox"/> | Fainting or Dizziness ..... | <input type="checkbox"/> |
| Rheumatic Fever ..... | <input type="checkbox"/> | Asthma .....             | <input type="checkbox"/> | Nervous Disorders .....     | <input type="checkbox"/> |
| Bone Disorders .....  | <input type="checkbox"/> | Kidney Involvement ..... | <input type="checkbox"/> | Liver Involvement .....     | <input type="checkbox"/> |
| Hepatitis .....       | <input type="checkbox"/> | Hypertension .....       | <input type="checkbox"/> | Thyroid Problems .....      | <input type="checkbox"/> |

Does patient have tendency to colds  Sore Throats  Ear Infections

Have tonsils and adenoids been removed? What age? \_\_\_\_\_ Yes  No

List any drugs or medications now being taken. Give reasons: \_\_\_\_\_

Is premedication required for dental procedures?  Yes  No Why? \_\_\_\_\_

List any allergies or drug sensitivity: \_\_\_\_\_

### DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? \_\_\_\_\_ Yes  No

Has the patient ever sucked a thumb or fingers? Until what age? \_\_\_\_\_ Yes  No

Does the patient have any speech problems? \_\_\_\_\_ Yes  No

Is the patient a mouth breather? While awake? \_\_\_\_\_ Yes  No

While asleep? \_\_\_\_\_ Yes  No

Does patient snore? \_\_\_\_\_ Yes  No

Have you been informed of any missing or extra permanent teeth? \_\_\_\_\_ Yes  No

Has an orthodontist been consulted previously? \_\_\_\_\_ Yes  No

Has either parent had orthodontic treatment? \_\_\_\_\_ Yes  No

When was your child's last dental check-up? \_\_\_\_\_

List any musical instruments played \_\_\_\_\_

Reason for consultation \_\_\_\_\_

Parent's Signature \_\_\_\_\_