



JEFFREY M. BARLOW DDS, PA

SPECIALIST IN ORTHODONTICS FOR CHILDREN AND ADULTS



Welcome to our office. We appreciate your completing our ORTHODONTIC CHILD ACQUAINTANCE CARD

TODAY'S DATE _____

PATIENT'S NAME _____ NICKNAME _____ DATE OF BIRTH _____ AGE _____

PATIENT'S ADDRESS _____ PATIENT'S EMAIL ADDRESS _____

HOME PHONE _____ SCHOOL _____ GRADE _____

FATHER'S NAME _____ SS# _____ DRIVER'S LIC. # _____

HOME ADDRESS _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

BUSINESS PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

DOES FATHER HAVE ORTHODONTIC INSURANCE? _____ INSURANCE COMPANY NAME: _____

MOTHER'S NAME _____ SS# _____ DRIVER'S LIC. # _____

HOME ADDRESS _____ DATE OF BIRTH _____

EMPLOYER _____ OCCUPATION _____

BUSINESS PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

EMERGENCY CONTACT: NAME _____ RELATIONSHIP _____ PHONE _____

DOES MOTHER HAVE ORTHODONTIC INSURANCE? _____ INSURANCE COMPANY NAME: _____

PATIENT'S DENTIST _____ DATE OF LAST DENTAL EXAM _____

PATIENT'S PHYSICIAN _____ IS PATIENT IN GOOD HEALTH? YES NO

IF NO, PLEASE EXPLAIN _____

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESSES OR HOSPITALIZATIONS? YES NO

HAS THE PATIENT BEEN UNDER THE CARE OF A PHYSICIAN? AGE _____ YES NO

IF YES, PLEASE EXPLAIN _____

HAS THERE BEEN ANY RECENT ILLNESS? _____

DOES THE PATIENT WEAR CONTACT LENSES? YES NO

CHECK THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Trouble/Chest Pain | <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Fainting/Dizziness |

(CONTINUED ON BACK)

DOES THE PATIENT NEED TO BE PRE-MEDICATED PRIOR TO ANY DENTAL PROCEDURES? YES NO

ALLERGY TO: Penicillin Codeine Aspirin Barbiturates Other _____

DOES PATIENT HAVE TENDENCY TO: Colds Sore Throats Ear Infections Canker Sores

HAVE TONSILS AND ADENOIDS BEEN REMOVED? _____ WHAT AGE? _____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN AND GIVE REASON: _____

HAS PATIENT REACHED PUBERTY? HEIGHT _____

GIRLS - Has she started menstruation? Yes No WEIGHT _____

IS THE PATIENT NOW EXPERIENCING A RAPID GROWTH "SPURT"? Yes No

HAS 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 THE PATIENT HAVE A NOSE OBSTRUCTION OR EXPERIENCE DIFFICULTY

IN BREATHING THROUGH THE NOSE? Yes No

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? Yes No

HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT? Yes No

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? Yes No

IF YES, PLEASE PROVIDE NAME: _____

LIST ANY MUSICAL INSTRUMENTS PLAYED _____

PARENT'S MAJOR CONCERN: _____

REFERRED BY: _____

NAMES & AGES OF SIBLINGS: NAME _____ AGE _____ NAME _____ AGE _____

NAME _____ AGE _____ NAME _____ AGE _____

Parent's Signature _____