CHILD ◆ ACQUAINTANCE ◆ FORM

HARDIE ORTHODONTICS
Diplomate American Board of Orthodontics
Practice Limited To Orthodontics

Date: _____

Child's Name _____ (LAST / FIRST / MI)

Child's Age _____ Date of Birth _____ ◇ Male ◇ Female

Address _____ (STREET / CITY / STATE / ZIP) Phone _____

School _____ Grade _____ Referred by _____

Parents/Guardian _____

Child's Dentist _____ Child's Physician _____

Parent's Information

First

Father _____ Occupation _____

Employer _____ Work Phone _____ Cell Phone _____

Work Address _____ (STREET / CITY / STATE / ZIP)

Father's Dental Insurance _____ SSN or ID No. _____

Group No. _____ Date of Birth _____

Email _____

Mother _____ Occupation _____

Employer _____ Work Phone _____ Cell Phone _____

Work Address _____ (STREET / CITY / STATE / ZIP)

Mother's Dental Insurance _____ SSN or ID No. _____

Group No. _____ Date of Birth _____

Email _____

Married ◇ Divorced ◇

Name and ages of other children in the family _____

Last

Medical History

Is your child in good health? ◇ Yes ◇ No

Does your child have any history of major illness? ◇ Yes ◇ No

Has your child ever been treated for an illness? ◇ Yes ◇ No

Check any of the following for which you child has been treated:

Diabetes	◇Yes ◇No	Kidney involvement	◇Yes ◇No
Pneumonia	◇Yes ◇No	Tuberculosis	◇Yes ◇No
Heart Trouble	◇Yes ◇No	AIDS	◇Yes ◇No
Rheumatic Fever	◇Yes ◇No	Prolonged Bleeding	◇Yes ◇No
Bone disorder	◇Yes ◇No	Fainting/dizziness	◇Yes ◇No
Herpes	◇Yes ◇No	Nervous disorders	◇Yes ◇No
Anemia	◇Yes ◇No	Liver involvement	◇Yes ◇No
Epilepsy	◇Yes ◇No	Endocrine problems	◇Yes ◇No
Asthma	◇Yes ◇No		

Do you have any other medical conditions not described above?
If yes, please explain: _____

Is your child prone to the following? ◇Yes ◇No
Colds?
Sore Throats
Ear Infections

Have the tonsils/adenoids been removed? ◇Yes ◇No
If so, at what age? _____

List any drugs/medications your child is taking and for what reasons: _____

List any allergy or drug sensitivity that your child has: _____

Has your child reached puberty? ◇Yes ◇No

Height _____ Weight _____

910 Grand Ave., Ste. E ◆ Escondido, CA 92025 ◆ p: 760-746-3450 ◆ f: 760-746-3583 ◆ escondido@sandiegoortho.com
16776 Bernardo Center Dr., Ste. 103 ◆ San Diego, CA 92128 ◆ p: 858-451-1800 ◆ f: 858-451-2479 ◆ ranchobernardo@sandiegoortho.com
1140 Main St., Ste. 209 ◆ Ramona, CA 92065 ◆ p: 760-789-0247 ◆ f: 760-789-8710 ◆ ramona@sandiegoortho.com

CHILD ◆ ACQUAINTANCE ◆ FORM

Last _____ First _____

Dental History

Have there been any injuries to your child's face/mouth/teeth? ◇ Yes ◇ No

Has your child ever sucked his/her thumb/fingers? ◇ Yes ◇ No
Until what age? _____

Does your child have any speech problems? ◇ Yes ◇ No

Is your child a mouth-breather? ◇ Yes ◇ No
While awake? ◇ Yes ◇ No
While asleep? ◇ Yes ◇ No

Does your child have any missing teeth? ◇ Yes ◇ No

Does your child have any permanent teeth? ◇ Yes ◇ No

Has an orthodontist been consulted? ◇ Yes ◇ No

Date of last cleaning at Dentist _____

Reason for consultation: _____

I have read and I understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any later changes to this history record or medical/dental status.

We will discuss your treatment with person(s) financially responsible for your treatment/referring doctor/dentist for the furtherment of your treatment.

By signing this, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

Thank you for filling out this form completely. It will enable us to provide you with better orthodontic care.

For Official Office Use

Study Model # _____

Date _____ Dr./Asst. _____

Cl=R OB= OJ= (Signature) Mid=

X-brite= Crowding= ↑ ; ↓ Profile=

CARIES Noted Yes/No Hygiene OCS= JAWS=

Fee est./Time est. N/V