San Ramon
ORTHODONTICS

ORTHODONTIC ACQUAINTANCE CARD

Patient's Name					
Res Address					
Date of Birth		**Age**		**Sex**	
Telephone number		**Referred by**			
School		**Grade**			
Patient's Dentist		**Physician**			
Father's Name		**Date of Birth**			
Res Address (if different from patient)					
Employed by		**Cellular Phone**			
Bus. Address		**S.S Number**			
Mother's Name		**Date of Birth**			
Res Address (if different from patient)					
Employed by		**Cellular Phone**			
Bus. Address		**S.S Number**			
Mother's Email		**Father's Email**			
Names and ages of other children in family	**Name:**		**Ages:**		
Do you have Orthodontic Insurance? ☐ **Yes** ☐ **No**					
Patient lives with	☐ **Mother**	☐ **Father**	☐ **Both**	☐ **Other**	

MEDICAL HISTORY

Is the patient in good health condition?	☐ **Yes**	☐ **No**			
Does the 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 you have been treated:

Diabetes	☐	Tuberculosis	☐	Endocrine Problems	☐
Pneumonia	☐	Anemia	☐	Prolonged Bleeding	☐
Heart Trouble	☐	Epilepsy	☐	Fainting or Dizziness	☐
HIV	☐	Asthma	☐	Nervous Disorders	☐
Bone Disorder	☐	Kidney Involvement	☐	Liver Involvement	☐

Does the patient have tendency to	**Colds** ☐	**Sore throats** ☐	**Ear Infections** ☐
Have Tonsils and Adenoids been removed?	☐ **Yes** ☐ **No**	**What age?**	
List any Drugs or Medication now being taken:	**Reasons:**		
List any Allergies or Drug Sensitivity:			
Has the patient reached puberty? ☐ **Yes** ☐ **No**	**GIRLS – Has she started menstruation**	**Height:**	
	BOYS – Has his voice changed	**Weight:**	

DENTAL HISTORY

Has there been any injuries to the face, mouth and 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**
Does the patient snore?		☐ **Yes**	☐ **No**
Is the patient a mouth breather	**While awake?**	☐ **Yes**	☐ **No**
	While asleep?	☐ **Yes**	☐ **No**
Have you been informed of any missing or extra permanent teeth?		☐ **Yes**	☐ **No**
		☐ **Yes**	☐ **No**
Has an Orthodontic treatment been consulted previously?		☐ **Yes**	☐ **No**
Has either parent had Orthodontic treatment?		☐ **Yes**	☐ **No**
Chief concern at Examination:			

Parent/Guardian Signature
Date:

Dr Karkhanechi, DDS.
Date:

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