San Ramon
ORTHODONTICS

ORTHODONTIC ACQUAINTANCE CARD

Patient's Name					
	LAST		FIRST		INITIAL
Res Address					
City		**State**		**ZIP**	
Phone		**Cell**		**Fax**	
E-mail Address		**Who may we thank for referring you?**			
Patient's Dentist		**Physician**			
Employed by		**Business Phone number**			
Soc Sec Num		**Date of Birth**			
Married ☐	**Single** ☐	**Separated** ☐	**Divorced** ☐	**Widowed** ☐	
Spouse Name					
Employed by		**Business Phone number**			
Soc Sec Num		**Date of Birth**			

Name and ages of other children in the family:	Name	Age
Do you have an Orthodontic Insurance? ☐ Yes ☐ No		

MEDICAL HISTORY

Are you in good health condition?		☐ **Yes**	☐ **No**
Do you have a history of major Illness?		☐ **Yes**	☐ **No**
Have you 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:

Venereal Disease	☐	Rheumatic Fever	☐	HIV	☐
Diabetes	☐	Bone Disorders	☐	Prolonged Bleeding	☐
Pneumonia	☐	Anemia	☐	Fainting or Dizziness	☐
High Blood Pressure	☐	Epilepsy	☐	Nervous Disorders	☐
Heart Trouble	☐	Asthma	☐	Liver Involvement	☐
Cancer	☐	Kidney Involvement	☐	Endocrine Problems	☐

Do you have a 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:	

DENTAL HISTORY

Has there been any injuries to the face, mouth and teeth?		☐ **Yes**	☐ **No**
Do you have any Speech Problems?		☐ **Yes**	☐ **No**
Are you a mouth breather	**While awake?**	☐ **Yes**	☐ **No**
	While asleep?	☐ **Yes**	☐ **No**
Have you been informed of any missing or extra permanent teeth?		☐ **Yes**	☐ **No**
Habits affecting the teeth?		☐ **Yes**	☐ **No**
Has either parent had Orthodontic treatment?		☐ **Yes**	☐ **No**
Has a Periodontist ever been consulted?		☐ **Yes**	☐ **No**
Reason for Consultation:			

Patient's Signature
Date:

Dr Karkhanechi, D.D.S.
Date: