DR. CAROL M. SUMME

• ORTHODONTIC ACQUAINTANCE FORM •

Date _____

Patient's name _____ Age ____ Sex _____ Date of birth _____
Home address _____ Zip _____ Telephone _____
Name Patient prefers to be called _____ E-Mail _____
Patient's Dentist _____ Physician _____
Whom may we thank for referring you? _____
Patient's school _____ Grade _____
Patient's Mother's name _____ Social Security # _____ Cell # _____
Occupation _____ Employed by _____ Work # _____
Home address _____ Home # _____
Patient's Father's name _____ Social Security # _____ Cell # _____
Occupation _____ Employed by _____ Work # _____
Home address _____ Home # _____
Is Patient adopted? ❑ Yes ❑ No Parent's Marital Status: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed
Patient's Step-parent's names _____
Names and ages of other children in family _____
Person financially responsible _____
Name of Dental Insurance company _____ Orthodontic Coverage ❑ Yes ❑ No

• MEDICAL HISTORY •

Does patient have any current health problems? ❑ Yes ❑ No Please list _____
Is patient under a physician's care now? ❑ Yes ❑ No Reason _____
Is patient currently taking any medications? ❑ Yes ❑ No Please list _____
Does patient have any history of major illness? ❑ Yes ❑ No Describe _____
Does patient have any developmental or learning disabilities? ❑ Yes ❑ No Describe _____
Is patient pregnant? ❑ Yes ❑ No Does patient take Birth Control Pills? ❑ Yes ❑ No
Does patient smoke? ❑ Yes ❑ No
Have tonsils and adenoids been removed? ❑ Yes ❑ No What age? _____
Does patient have any allergies? ❑ Yes ❑ No Please list _____
Does patient have tendency to: ❑ Colds ❑ Sore Throats ❑ Ear Infection ❑ Fever Blisters ❑ Cold Sores (Inside Mouth)
Has patient reached puberty? Girls Has she started menstruation? ❑ Yes ❑ No Date _____
Boys Has his voice changed? ❑ Yes ❑ No Date _____
Height _____ Weight _____
Has your child ever been advised to be premedicated for dental appointments? ❑ Yes ❑ No

Circle any of the following which the patient has had or has at present:

Heart Failure	Heart Pacemaker	Hepatitis A (Infectious)	Fainting or Dizzy Spells	Bruise Easily	X-Ray or Cobalt Treatment
Heart Disease or Attack	Heart Surgery	Hepatitis B (Serum)	Nervousness	Emphysema	Arthritis
Angina Pectoris	Artificial Joints (Hip, Knee)	Liver Disease	Psychiatric Treatment	Tuberculosis (TB)	Rheumatism
High Blood Pressure	Anemia	Yellow Jaundice	Sickle Cell Disease	Asthma	Cortisone Medicine
Heart Murmur	Stroke	Blood Transfusion	Glaucoma	Hay Fever	Pain in Jaw Joints
Rheumatic Fever	Kidney Trouble	Drug Addiction	Chemotherapy	Sinus Trouble	Alcoholism
Congenital Heart Lesions	Ulcers	Hemophilia	(Cancer, Leukemia)	Allergies or Hives	Bleeding Problems
Scarlet Fever	Cosmetic Surgery	Fever Blisters	Venereal Disease	Diabetes	
Artificial Heart Valve	A.I.D.S.	Epilepsy or Seizures	(Syphillis, Gonorrhea, etc.)	Thyroid Disease	

Is patient allergic to or has reacted adversely to any of the following medications?
❑ Aspirin ❑ Percodan ❑ Erythromycin ❑ Darvon ❑ Local Anesthetic ❑ Valium ❑ Nitrous Oxide ❑ Codeine ❑ Penicillin

Are you aware of being allergic to any other medications or substances? ❑ Yes ❑ No If yes, please list: _____

• DENTAL HISTORY •

Have there been any injuries to the face, mouth, or teeth? ❑ Yes ❑ No Describe _____
Has the patient ever sucked a thumb or fingers? ❑ Yes ❑ No Until what age? _____
Does the patient have any speech problems? ❑ Yes ❑ No
Is patient a mouth breather? While sleeping? ❑ Yes ❑ No While awake? ❑ Yes ❑ No
Have you ever been informed of any missing or extra permanent teeth? ❑ Yes ❑ No
Has an orthodontist been consulted previously? ❑ Yes ❑ No
Has patient had any previous orthodontic treatment? ❑ Yes ❑ No
Has patient ever had any TMJ (Jaw Joint) problems? ❑ Yes ❑ No
What are you or your dentist most concerned about? (Purpose of this visit) _____

Parent's signature _____