Member
American Association of
Orthodontists

GLAUSER & WILLIAMS ORTHODONTICS

ORTHODONTICS FOR CHILDREN AND ADULTS

Acquaintance Card and History

Date_____

Patient's Name_____Sex_____Age_____

Date of Birth_____School_____Grade_____

Home Address_____City_____Zip_____

Home Cell
Patient E-Mail_____ Phone_____Phone_____

Father's Name _____SS# _____Birth Date ____/____/____

Work
Employer_____Phone_____

Cell
Father's Address_____ Phone_____

Mother's Name _____SS# _____Birth Date ____/____/____

Work
Employer_____Phone_____

Cell
Mother's Address_____ Phone_____

E-Mail: Father_____Mother_____

Patient lives with__Mother___Father___Both parents in same residence_____Other(please specify)_____

Referred by_____

Family Dentist_____Phone_____

Family Physician_____Phone_____

Do you have Dental insurance? _____Is orthodontics covered? _____:

Primary_____ Employee_____

Secondary_____Employee_____

CHECK THE APPROPRIATE BOX
Does the patient have or ever had any of the following:?

	Yes	No		Yes	No
Rheumatic Fever…….	____	____	Speech Problems…….	____	____
Convulsions or Epilepsy…….	____	____	Any habits; Lip Biting, Thumb Sucking		
Tuberculosis……..	____	____	Nail Biting, Other (Circle)……	____	____
Asthma or Hay fever…….....	____	____	Tonsils or Adenoids Removed……...	____	____
Allergic reactions to Medication……..	____	____	Injury to Baby or Permanent Teeth.. …	____	____
List_____			Describe_____		
Has patient ever been seen by an orthodontist……. ……	____	____	Hepatitis?……	____	____
			A heart murmur?…… .	____	____
Is patient pregnant?……	____	____	Is the patient in good health now?……	____	____
Were there any complications in pregnancy or delivery of the patient?	____	____	If no, explain_____ Diabetes…… .	____	____
If yes, explain_____			In your own words, what is the orthodontic problem?		
Is the patient taking any medication?	____	____	_____		
What?_____			Age of brothers and sisters_____		
Do you have any artificial joints or heart valves?…….	____	____	Has any family member had orthodontics.	____	____
			Who?_____		
Difficulty Breathing…….	____	____	Were the results acceptable?……	____	____
Aids…….	____	____	HIV Positive…… ….	____	____

_____
Signature and Relationship to Patient

OFFICE USE ONLY
Soft tissue check_____ _____
Doctor Signature