

# DR. HOLT'S ORTHODONTIC ACQUAINTANCE FORM

## PATIENT INFORMATION:

Patient full name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_, CA Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Dentist: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
Hobbies & Interests: \_\_\_\_\_  
Patient likes to be called: \_\_\_\_\_  
If a student, School and Grade: \_\_\_\_\_

## 1<sup>st</sup> RESPONSIBLE PARTY INFORMATION:

Name: _____
Relationship to Patient: _____
<input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
Responsible Party Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address: _____
Home Telephone: _____
Work Telephone: _____
Cell Telephone: _____
Email: _____
Employer: _____
Occupation: _____
<b>INSURANCE</b>
Dental Insurance Carrier: _____
Subscriber Name: _____
SSN or ID Number: _____
Subscriber Birthdate: _____
Group# _____

## 2<sup>nd</sup> RESPONSIBLE PARTY (IF APPLICABLE):\*

Name: _____
Relationship to Patient: _____
<input type="checkbox"/> Self <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____
Responsible Party Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address: _____
Home Telephone: _____
Work Telephone: _____
Cell Telephone: _____
Email: _____
Employer: _____
Occupation: _____
<b>INSURANCE</b>
Dental Insurance Carrier: _____
Subscriber Name: _____
SSN or ID Number: _____
Subscriber Birthdate: _____
Group # _____

\*If there are 2 responsible parties (in different households):

Is custody shared?  No  Yes @ \_\_\_\_\_/\_\_\_\_\_%

With whom does the patient primarily reside? \_\_\_\_\_ Is there a court order regarding Insurance? \_\_\_\_\_

## MEDICAL HISTORY:

Is patient in good health? Yes  No   
Has he/she been treated by a physician in the last 2 years? Yes  No   
Is he/she taking any medications now? \_\_\_\_\_

List any allergies: \_\_\_\_\_

Has patient ever had any of the following?

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Asthma            | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Heart Murmur       | <input type="checkbox"/> Tonsillitis     |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Brain Injury       | <input type="checkbox"/> Anemia          |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> Other: _____    |

## DENTAL HISTORY:

Please check if there is a history of any of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Jaw joint popping | <input type="checkbox"/> Noise/pain in jaw or ears | <input type="checkbox"/> Uncomfortable Bite      | <input type="checkbox"/> Clenching/grinding teeth |
| <input type="checkbox"/> Mouth breather    | <input type="checkbox"/> Frequent headaches        | <input type="checkbox"/> Injury to head/neck/jaw | <input type="checkbox"/> Sucked thumb/fingers     |
| <input type="checkbox"/> Missing teeth     | <input type="checkbox"/> Extra teeth               | <input type="checkbox"/> Previously Treated TMJ  | Year stopped _____                                |

If patient is a child, list the names and ages of brothers and sisters: \_\_\_\_\_

Have others in the family had a similar condition or received orthodontic treatment? Yes  No

Has patient had any previous orthodontic treatment or consultations? Yes  No

When did patient last visit the Dentist? \_\_\_\_\_

Any specific problem you would like us to fix? \_\_\_\_\_

I, \_\_\_\_\_ (print name) attest that the above information is true and accurate and authorize (if applicable) Dr. Holt's office to bill insurance for treatment. I also acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_