John E. Ogro, D.D.S.

Child Orthodontic Acquaintance Form

PATIENT INFORMATION:
Name: ______________________________
Street: ______________________________
City, State Zip ________________________
Birthdate: ___________________________
Dentist: _____________________________
Referred by : _________________________

BILLING INFORMATION:
Name: ______________________________
Street: ______________________________
City, State Zip ________________________
Phone: ______________________________
Mobile: _____________________________
Email: ______________________________

DENTAL INSURANCE INFORMATION

Insured's **Full Name**:_______________________________ **Insured's** Date of Birth ____________
Insured's Social Security # or ID#____
Patient's **Full Name**: ____
Employer____Phone_(____)________________
DENTAL INS. CARRIER _________________________ Group No. _________Tele No. ___________
Address ____
Street City State Zip

MEDICAL HISTORY:

Has the patient had his or her tonsils or adenoids removed? yes____ no____
Does the patient have frequent colds or ear infections? yes___ no____
Does the patient have any history of major illness? yes____ no____
If so, please describe ____
Does the patient require pre-medication prior to dental visits? yes____ no____
Does the patient have any drug sensitivities or allergic reactions? yes____ no____
If so, please list ____
Is the patient presently taking any medication? yes____ no____
If yes, please list ____
Is the patient under medical care now, other than routine? yes____ no____
Physician's name ________________________________ Phone # _________________

Please check any of the following for which the patient has been treated:

___ Diabetes ___ Asthma ___ Prolonged Bleeding
___ Arthritis ___ Epilepsy ___ Nervous Disorders
___ Heart Trouble/Murmur ___ Rheumatic Fever ___ Hepatitis
___ AIDS/ARC ___ Brain Injury ___ Tuberculosis

DENTAL HISTORY:

Has the patient suffered any severe injury to the face? yes____ no____
Are you aware of any missing permanent teeth? yes____ no____
Does the patient clench or grind their teeth? yes____ no____
Does the patient have pain or clicking upon closing? yes____ no____
Has the patient had any previous orthodontic treatment? yes____ no____
When did the patient last visit their dentist?____

COMMENTS:

____
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Please be sure to bring this form with you for the examination appointment. **Thanks!**

____ ________________
Signature Date