MATTHEW L. MOLITOR, *D.D.S., M.S.* ORTHODONTIC AQUAINTANCE FORM

Patient Information: ☐ Male ☐ Female Today's date _____/_____/_____

Name _____ Birthdate _____/_____/_____

Name he or she likes to be called _____ ☐ Patient's Email _____

Home Address _____

Home (_____) - _____ - _____ Patient's Cell (_____) - _____ - _____

School _____ Grade _____

Sports/Hobbies _____

# of brothers _____ Age(s) _____ # of sisters _____ Age(s) _____

Physician's Name _____ Dentist's Name _____

Whom may we thank for referring you to our office?_____

Briefly describe the problem and/or reason for seeking an orthodontic evaluation: _____

_____

Relationship to patient: **Mother** ☐ **Stepmother** ☐ **Guardian** ☐ **Other** ☐ _____

☐ Mrs ☐ Ms ☐ Dr Name_____ DOB _____/_____/_____

Home (_____) - _____ - _____ Work (_____) - _____ - _____ ☐ Cell (_____) - _____ - _____

Employer _____ ☐ Email _____

Relationship to patient: **Father** ☐ **Stepfather** ☐ **Guardian** ☐ **Other** ☐ _____

☐ Mr. ☐ Dr Name_____ DOB _____/_____/_____

Home (_____) - _____ - _____ Work (_____) - _____ - _____ ☐ Cell (_____) - _____ - _____

Employer _____ ☐ Email _____

Person Responsible for this Account:

Name _____ Relationship_____

Billing Address _____ SS # _____ - _____ - _____

Employer _____ Work (_____) - _____ - _____

Appointment Reminders: A maximum of 4 appointment reminders can be sent (2 email, 2 text). Please check the box ☑ next to any (patient and/or responsible party below) you would like reminders sent to.

Continued on other side…

MEDICAL HISTORY

Has the patient been diagnosed or treated for any of the following? If no, please select "None"

☐ Diabetes	☐ HIV	☐ Endocrine Disorder
☐ Epilepsy	☐ Fainting	☐ Prolonged Bleeding
☐ Asthma	☐ Hepatitis	☐ Emotional Difficulties
☐ Arthritis	☐ Cerebral Palsy	☐ Rheumatic Fever
☐ Anemia	☐ Bone Disorder	☐ Heart Trouble

☐ **NONE**

Yes	**No**	
☐	☐	Is the patient adopted? At what age? _____
☐	☐	Have antibiotics been recommended for dental visits?
☐	☐	Is the patient allergic to anything? If so what? _____ _____
☐	☐	Have the tonsils or adenoids been removed?
☐	☐	Is the patient presently under the care of a physician? For? _____
☐	☐	Is the patient taking any medications?_____ _____
☐	☐	Has the patient had any major surgery? For? _____
☐	☐	Does the patient have a chronic problem with: ☐ Kidney ☐ Heart ☐ Lungs ☐ Liver

Has the patient reached puberty?

Yes	**No**	
☐	☐	Menstruated (girls) Approx. date _____
☐	☐	Voice Change (boys) Approx. date _____

Are there any other medical problems not mentioned above or additional information we should know about?

Describe: _____

_____

_____

_____

DENTAL HISTORY

Yes	**No**	
☐	☐	Has the patient ever sucked his/her thumb or fingers? Until what age? _____
☐	☐	Does the patient breathe predominantly through his/her mouth?
☐	☐	Does the patient have any speech problems?
☐	☐	Does the patient clench or grind teeth at night or during the day?
☐	☐	Does the patient experience jaw joint clicking or pain upon opening or closing his/her mouth?
☐	☐	Has the patient had any severe head or face injuries?
☐	☐	Have any teeth been injured or chipped? When? _____
☐	☐	Has a dentist informed you or the patient of any extra teeth or missing teeth?
☐	☐	Were any teeth (baby or permanent) removed by extraction?
☐	☐	Has a dentist ever placed a retainer or space maintainer?
☐	☐	Has any member of your family had orthodontic treatment? Who? _____
☐	☐	Has the patient had any previous orthodontic consultations or treatment?
☐	☐	Does anyone in the family have a similar dental condition?
☐	☐	Would the patient mind wearing braces?
☐	☐	Would the patient mind wearing headgear?
☐	☐	Has the patient had any noticeable difficulty in chewing or swallowing food?
☐	☐	Has the patient ever been teased about the appearance of his/her teeth?
☐	☐	Is the patient concerned about the appearance of his/her teeth?
☐	☐	Does the patient want his/her teeth straightened?
☐	☐	Are you aware that some appointments will infringe on school time?

Approx. date of last dental appointment: _____

I acknowledge that the above information is true and complete.

Parent/Resp. Party signature_____ Date _____