LASKI ORTHODONTICS

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Child Orthodontic Acquaintance Form

Patient's Name: _____ Date: _____
Date of Birth: ____ MM ____ DD ____ YY Age: _____ Sex: _____ School/Grade: _____
Home Address: _____ City: _____ Postal: _____
Number of children in family: _____ Ages & names of other children: _____
Patient's Dentist: _____ Physician: _____ Physician's Tel: _____
Who may we thank for referring you? _____
Mother's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home
Father's Name: _____ Home Tel: _____ Daytime Tel: _____ □ Cell □ Work □ Home
Person responsible for account: _____
Do you have an insurance plan that covers orthodontic treatment? □ Yes □ No □ Unsure E-mail: _____

MEDICAL HISTORY - HAS THE CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

Rheumatic Fever	□ Yes □ No	Tuberculosis	□ Yes □ No	Diabetes	□ Yes □ No
Heart Murmur	□ Yes □ No	H.I.V. / A.I.D.S.	□ Yes □ No	Kidney Disorder	□ Yes □ No
Mitral Valve Prolapse	□ Yes □ No	Hepatitis A, B, or C	□ Yes □ No	Liver Disease	□ Yes □ No
Heart Disease	□ Yes □ No	Sexually Transmitted Diseases	□ Yes □ No	Asthma	□ Yes □ No
Artificial Heart Valve	□ Yes □ No	Blood Pressure	□ Yes □ No	Arthritis	□ Yes □ No
Artificial Joints	□ Yes □ No	Prolonged Bleeding	□ Yes □ No	Other _____	

If you responded YES to any of the above questions, please give pertinent information: _____
_____
Is the child in good health? _____
List any drugs or medications now being taken: Please give reasons: _____
Does the child have any history of major illness and/or operations? _____
List any allergies or drug sensitivities: _____
Have tonsils or adenoids been removed? □ Yes □ No At what age? _____
Does the child have a tendency to colds? □ Yes □ No Sore Throats? □ Yes □ No Ear Infections? □ Yes □ No
Has the patient reached adolescent growth? □ Yes □ No

DENTAL HISTORY

Has the child ever been treated for a jaw joint problem, including surgery? □ Yes □ No
Have there been any injuries to the face, mouth or teeth? □ Yes □ No Please describe: _____
Has the child ever sucked his/her thumb or finger? □ Yes □ No Until what age? _____
Does the child have any speech problems? □ Yes □ No
Does the child have frequent canker or cold sores? □ Yes □ No
Is the child a mouth breather? While Asleep: □ Yes □ No While Awake: □ Yes □ No
Have you been informed of any missing or extra permanent teeth? □ Yes □ No
Has the child ever had a previous orthodontic examination? □ Yes □ No
Is the child especially apprehensive towards dental visits? □ Yes □ No
Does the child want orthodontic treatment? □ Yes □ No
Has any other family member had braces or orthodontic treatment? □ Yes □ No
Please name the family member if treated in our office: _____
When did the child last see the family dentist? _____
List any sports, hobbies or musical instruments played: _____
Reason for orthodontic consultation: _____

I hereby give Dr. Sol Laski and/or Dr. Brian Laski and/or members of their staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment plan or treatment in progress.

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____
Signature of Parent or Legal Guardian Date