ALBERT M. STUSH, JR., D.M.D., M.S., P.C.
SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

CHILD ORTHODONTIC ACQUAINTANCE CARD

Date: _____ Birthdate: _____

Patient's Name: _____ Nickname: _____ Age: _____ Sex: _____

Address: _____
Street City State Zip Code

Telephone: _____ Email: _____

School: _____ Grade: _____

Referred By: _____ Patient's Dentist: _____

Have you visited our office previously? _____

How did you happen to call our office? _____

Patient's Physician: _____
Name Address

Patient's Oral Surgeon: _____

Father's Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Telephone: _____ Driver License # _____ SS#: _____

Father's Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Telephone: _____ Email: _____

May we contact you at your place of employment? _____

When is the best time to contact you? _____

Mother's Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Telephone: _____ Driver License # _____ SS#: _____

Mother's Employer: _____ Occupation: _____

Address: _____
Street City State Zip Code

Telephone: _____ Email: _____

May we contact you at your place of employment? _____

When is the best time to contact you? _____

Names and ages of other children in the family: _____

_____

Are parents divorced? Yes / No

Who is responsible for payment of account? _____

Orthodontic insurance coverage? Yes _____ No _____ Company _____

Policy # _____ Group # _____

** This information may be used to obtain a credit history report. **

CHILD MEDICAL HISTORY

PLEASE READ CAREFULLY - ANSWER EACH QUESTION ACCURATELY

1. Is your child in good health?
_____ Yes _____ No _____

2. Does your child have any history of major illness?
_____ Yes _____ No _____

3. Please draw a circle around any of the following which your child has had or may have at present.

Heart Disease	Pneumonia	Tuberculosis (TB)	Attention Deficit Disorder
Heart Condition	Gland problems	Unexplained weight loss	Seizures
Chest pains	Hemophilia	Bone disorders	Endocrine problems
High blood pressure	Bleeding disorders	Diabetes	Dizzy spells
Shortness of breath	Bruises easily	Ulcers	AIDS
Swollen ankles	Prolonged bleeding	Kidney trouble	AIDS related complex
Artificial heart valve	Anemia	Liver disease	HIV positive
Congenital heart disease	Blood transfusion	Jaundice	Cold sores
Heart murmur	Arthritis	Hepatitis	Genital herpes
Rheumatic fever	Asthma	Thyroid disease	Venereal disease
Stroke	Hay fever	Glaucoma	Cancer
Chemotherapy	Emphysema	Epilepsy	Radiation therapy
Emotional problems	Implant prosthesis	ADHD	Hyperactivity
Artificial joints/Implants	Heart valve		

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. *IF IN DOUBT, CIRCLE YES.*

4. Is your child presently, or has your child been under the care of a physician during the past year? Why?	**YES**	**NO**
5. Is your child presently taking any medicine or drugs? Please list.	**YES**	**NO**
6. Is your child allergic to any medicine or materials? Please list.	**YES**	**NO**
7. Has your child ever had a reaction to local anesthetic?	**YES**	**NO**
8. Has your child ever experienced any complication or illness following a dental treatment?	**YES**	**NO**
9. Does your child have any diseases or conditions not listed above? Please list.	**YES**	**NO**
10. Has your child ever been told he/she was not eligible to be a blood donor? Why?	**YES**	**NO**
11. Does your child use tobacco? Smoke? Smokeless? Frequency? _____	**YES**	**NO**
12. WOMEN ONLY: Is your child pregnant or do you think she may be pregnant? If yes, circle trimester: 1st 2nd 3rd	**YES**	**NO**

Parent Comments:

Signature of Parent _____ Date _____

Orthodontist's Comments:

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