Oakland Orthodontics
Archana Dhawan DDS, MS

GET ACQUAINTED QUESTIONNAIRE

FOR PATIENTS UNDER 18 YEARS OF AGE

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's Full Name----------Date Of Birth----------Age-------- Phone----------
Address----------City ---------- State------- Zip----------
Email Address---------- Cell Phone----------
Family Dentist---------- City----------Phone----------Last Visit----------
Family Physician---------- City----------Phone----------
School----------Grade----------Name patient likes to be called----------
Sports,Hobbies,etc.----------Musical Instrument played----------
Parents' Full Names----------
Siblings (names/ages)----------
Parents:Married----------Separated----------Divorced----------Widowed----------Single----------
Siblings having had orthodontic treatment----------
Major reason for seeking orthodontic treatment----------
How did you hear about our office?----------

DENTAL HISTORY

	NO	UNSURE	YES	
Has there been a thumb or finger habit?	☐	☐	☐	notes:----------
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐	notes:----------
Are you aware of any missing or extra permanent teeth?	☐	☐	☐	notes:----------
Has the patient had any speech problems or therapy?	☐	☐	☐	notes:----------

Does the patient:

● clench or grind his/her teeth?	☐	☐	☐	notes:----------
● brush his/her teeth conscientiously?	☐	☐	☐	notes:----------

Does the patient have:

● a history of periodontal (gum) problems?	☐	☐	☐	notes:----------
● a problem with frequent cold/canker sores?.....	☐	☐	☐	notes:----------
● any difficulty opening his/her mouth?	☐	☐	☐	notes:----------
● any clicking or discomfort in jaw joints near ears?	☐	☐	☐	notes:----------
● headaches or neck aches regularly?	☐	☐	☐	notes:----------
● pain in the jaw joints while eating?	☐	☐	☐	notes:----------
● any congenital abnormalities? (cleft palate, etc.)	☐	☐	☐	notes:----------

ATTITUDE TOWARD TREATMENT

Is the patient aware of spaced, crooked or protruding teeth? ..... ☐ No.... ☐ Yes Concerned?..... ☐ No... ☐ Yes
Do you feel that it is becoming..... ☐ Better..... ☐ Worse..... ☐ Staying the Same
What would you most like to have orthodontic treatment accomplish?----------
Would the patient object to wearing orthodontic appliances (braces) should they be indicated? ..... ☐ No .....☐ Yes
Are you aware that some appointments will infringe upon school/work time? .....☐ No.....☐ Yes
Has the patient had any previous orthodontic examinations? ....☐ No....☐ Yes.. Doctor:---------- Date:----------
Previous Orthodontic Treatment?---------- Describe----------

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

Please check no or yes to the following and indicate the year:

	No	Yes	Years		No	Yes	Years
Attention Deficit Disorder	.....	.....	.....	Hay Fever	.....	.....	.....
Allergies	.....	.....	.....	Healing Disorder	.....	.....	.....
Anemia or Bleeding Problems	.....	.....	.....	Headaches	.....	.....	.....
Arthritis	.....	.....	.....	Hearing Disorder	.....	.....	.....
Asthma	.....	.....	.....	Heart Disorders (murmur,etc.)	.....	.....	.....
Behavioral Problems	.....	.....	.....	Hepatitis or Liver Disorders	.....	.....	.....
Bone or Joint Disorder	.....	.....	.....	HIV Positive	.....	.....	.....
Breathing or Nasal Disorder	.....	.....	.....	Kidney or Bladder Condition	.....	.....	.....
Diabetes	.....	.....	.....	Mononucleosis	.....	.....	.....
Earaches	.....	.....	.....	Nervous Disorders	.....	.....	.....
Epilepsy or Convulsions	.....	.....	.....	Psychiatric Treatment	.....	.....	.....
Fainting or Dizziness	.....	.....	.....	Psychological Disorder	.....	.....	.....
Gagging or Nausea Problems	.....	.....	.....	Rheumatic Fever	.....	.....	.....
Growth or Endocrine Condition	.....	.....	.....				

General health: Good ---------- Fair ---------- Poor ---------- Birth Defects----------

Presently under medical care for----------

Drugs or medication being taken now (drug and dose)----------

Allergic to any medication----------

Does the patient require antibiotic premedication prior to dental appointments?--------- No.... Yes

Is the patient a mouth breather?..... No..... Yes.....While asleep..... While awake

Have tonsils and adenoids been removed? ..... No..... Yes..... At what age?

Does the patient snore at night?..... No..... Yes

Growth in the past 6 months:----------

Has the patient reached puberty?..... No..... Yes

Height: ..... Patient's ---------- Mother's---------- Father's ----------

RESPONSIBLE PARTY INFORMATION

Name----------

Residence ----------

Mailing Address----------

How long at this address----------HomePhone----------WorkPhone----------

Previous Address (if less than 3 yrs)----------

SocialSecurity#----------Birthdate---------- Relationship to patient ----------

Employer---------- Occupation---------- No.of Years employed ----------

Spouse's Name---------- Relationship to Patient ----------

Spouse's Address ----------

Employer---------- Occupation----------No.Years Employed----------

Social Security # ---------- Birthdate---------- Work Phone----------

Name of nearest relative not living with you ----------

Home Phone Work Phone

ORTHODONTIC INSURANCE INFORMATION

Insurance Company----------Group No----------Local No----------

Insurance Co. Address ----------

Insured's Name ----------Insured's Soc. Sec. # ----------

Insured's Employer ----------

Do you have dual coverage?----------No----------Yes If Yes:----------

Insurance Company----------Group No.----------Local No.----------

Insurance Co. Address ----------

Insured's Name ----------Insured's Soc. Sec. # ----------

Signature of parent or guardian ----------Date ----------

I give permission for patient records to be used for research/educational purposes.----------Initials

I give permission for pictures of my child to be used on our website or social network.----------Initials