SIREE
ORTHODONTICS

GET ACQUAINTED QUESTIONNAIRE - CHILD

The following information is needed to enable us to give you the most consideration and best services possible. Please have **ALL** sides of the form filled out **BEFORE** your appointment. This information is of course confidential. Thank you.

Patient's Full Name_____ Preferred Name_____

Social Security Number _____ Sex: M/F_____ Age: _____ Birthdate: _____

Home Address _____ City _____ Zip Code _____

Cell Phone # (_____)_____Height: ft _____in _____ Weight_____lbs

School_____

Likes or Dislikes School/ Why _____

Hobbies _____

Patient's Dentist_____ Phone # (____)_____

Date of last cleaning and check-up_____

Had unfavorable reaction to dental care?_____

What is the patient's (or parents) primary concern_____

What are your feelings about braces?_____

Have you ever been seen by an orthodontist?_____

How many brothers do you have? _____Their Age_____

How many sisters do you have? _____Their Age_____

Do they have any orthodontic problems?_____

Have they had any orthodontic treatment?_____

Name(s) of siblings treated in our practice_____

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

We want to thank you for your cooperation in supplying the above information.

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FAMILY INFORMATION

Father's name _____ Phone # _____

Home Address _____City _____ Zip code _____

Marital Status S M SEP D W

Occupation _____ Employer_____ Business ph # _____

Social Security_____Email address _____

Mother's name _____ Phone # _____

Home Address _____City _____ Zip code _____

Marital Status S M SEP D W

Occupation _____Employer_____ Business ph # _____

Social Security_____Email address _____

HEALTH INFORMATION

- ❑ Any Heart Disease
- ❑ Any Respiratory
- ❑ Any Blood Disease
- ❑ Any Broken Bones
- ❑ Any Thyroid Disease
- ❑ Any Kidney/Liver Disease
- ❑ H.I.V Positive
- ❑ Any Venereal Disease
- ❑ Any Intestinal Disease
- ❑ Any Bone Disease
- ❑ Allergic to Anything
- ❑ Any Endocrine Problems
- ❑ Any Prolonged Bleeding
- ❑ Had a Physical this year
- ❑ Rheumatic/Yellow/Scarlet Fever
- ❑ Acquired Immune Deficiency Syndrome
- ❑ Is Patient Under Medical Care
- ❑ Anemia
- ❑ Polio
- ❑ Epilepsy
- ❑ Latex Allergy
- ❑ Fever Blisters
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Blood Transfusions
- ❑ Chemical Dependency
- ❑ Radiation Therapy
- ❑ Hemophilia
- ❑ Asthma or Hay Fever
- ❑ Rheumatism/ Arthritis
- ❑ Any Tumors or Cancer
- ❑ Any History of Fainting or Dizziness
- ❑ Any Nervous/Emotional Problems
- ❑ Does the patient smoke
- ❑ Any drug addiction
- ❑ Is the patient pregnant at this time
- ❑ Heart Murmur
- ❑ Mononucleosis
- ❑ Hepatitis
- ❑ Emphysema
- ❑ Measles/Mumps/Chicken Pox
- ❑ Is the patient in good health
- ❑ Any High/Low blood pressure
- ❑ Has the patient reached puberty

Medications taken _____

DENTAL HISTORY

- ❑ Has the patient seen a general dentist in the last year
- ❑ Any pain, clicking or discomfort in or near the ears
- ❑ Has the mouth face or teeth been injured by a fall or accident
- ❑ Have you been informed of missing or extra permanent teeth
- ❑ Are you aware of any gum problems
- ❑ Have patients tonsils or adenoids been removed
- ❑ Do you feel the patient can benefit from orthodontic treatment
- ❑ Is the patient happy with their SMILE
- ❑ Does the patient want to improve their SMILE
- ❑ Would the patient mind wearing BRACES
- ❑ Does the patient have or ever had any of the following habits
  - ❑ Cheek/tongue or lip chewing
  - ❑ Thumb sucking
  - ❑ Mouth Breathing
  - ❑ Finger nail biting
  - ❑ Clenching teeth
  - ❑ Tongue thrusting
  - ❑ Grind Teeth
  - ❑ Speech Problem

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Date _____ Signature _____

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