



IDALIA LASTRA, D.M.D.

CHILD ORTHODONTIC ACQUAINTANCE FORM

Welcome to our office! In order to best serve you, we need some information for our records. Please try to answer all the questions. Feel free to ask our staff for help if needed. Thanks!

Date _____

Patient's Name _____ Sex _____ S.S.# _____

First Middle Initial Last

Nickname _____ Age _____ Birthdate (month) _____ (day) _____ (year) _____

School _____ Grade _____

Home Address _____ City _____ State _____ Zip _____ Home phone _____

Who will be bringing patient to their appointments? _____ Relation _____

First Last

Address _____ City _____ State _____ Zip _____ Home phone _____

Occupation _____ Employer _____ Work phone _____

Who will be responsible for this account? _____ Relation _____

First Last S.S.#

Address _____ City _____ State _____ Zip _____ Home phone _____

Occupation _____ Employer _____ Work phone _____

Dentist _____ Last visit _____ Who may we thank for telling you about our office? _____

Have you ever seen an Orthodontist before? _____ When? _____ Orthodontist's name? _____

Have you ever worn braces? _____ Orthodontist _____ City _____ State _____ How long in treatment? _____

Are you covered by insurance for orthodontic treatment? _____ Insurance Company _____

Why did you come to see us? _____

What would you like to change about your child's teeth? _____

What do you feel may have caused these problems? _____

How does the patient feel about braces? _____

Are there other family members with a similar orthodontic condition? _____

Has any other family member worn braces? _____ If so, whom? _____

Any oral habits? Finger sucking _____ Tongue thrust _____ Pencil, nail, or lip biting _____ Mouth breathing _____ Grinding _____ Clenching _____

Temporomandibular joint symptoms? Headaches _____ Clicking _____ Locking _____ Pain _____ Limited opening _____ Dizziness _____ Other _____

Medical History Physician _____ General Health _____

Any history of: Allergy _____ Arthritis _____ Asthma _____ Anemia _____ Blood Disease _____ Convulsions _____ Congenital defects _____

Diabetes _____ Epilepsy _____ Glands (endocrine) _____ Heart _____ Heart Murmur _____ Hepatitis _____ Jaundice _____ Kidney _____

Liver _____ Lung Disease _____ Rheumatic Fever _____ Sinus _____ Tuberculosis _____ HIV _____ AIDS _____ Pregnancy? _____ How long? _____

Do you have any disease, condition, or problem not listed above that we should know? _____

Any medications being taken? _____ Any operations? _____

No. of Brothers _____ Ages _____ No. of Sisters _____ Ages _____

Speech problems? _____ Puberty: Girls – Has menstruation begun? _____ When? _____ Boys – Has voice changed? _____ When? _____

Hobbies _____ Music Lessons _____ Sports _____

Signature _____ Relation _____