Patient Acquaintance FORM

Dr. Dan C. Peavy
Orthodontics for Adults & Children
Diplomate American Board of Orthodontics

Patient's Name: ____________ (LAST) (FIRST) (NICKNAME) Sex: M☐ F☐ Birthdate: ________ Height: ________
Address: ____________ (ZIP) Home Phone: ________ SSN: ___-___-___
School/Employer: ____________ Work/Cell Phone: ________ Grade: ________
Interests, Hobbies: ____________ E-mail: ________

Father/Husband Name: ____________ (LAST) (FIRST) (NICKNAME) Home Phone: ________ SSN: ___-___-___
Address: (Same ☐) ____________ (ZIP) Work/Cell Phone: ________
Employer/Occupation: ____________ E-mail: ________

Mother/Wife Name: ____________ (LAST) (FIRST) (NICKNAME) Home Phone: ________ SSN: ___-___-___
Address: (Same ☐) ____________ (ZIP) Work/Cell Phone: ________
Employer/Occupation: ____________ E-mail: ________

Siblings/Children? Names (Ages) ________ ( ) ________ ( ) ________ ( )

Whom may we thank for referring you? Dentist☐ Other ☐ Name/Address: ________

Chief Concerns: ________

Evaluate (Good, Fair, Poor): Cooperation: G☐ F☐ P☐ Toothbrushing: G☐ F☐ P☐ Attitude Toward Treatment: G☐ F☐ P☐

Dental History SUMMARY

Patients family dentist: ________ Date of last visit ________

Any family member seen Dr. Peavy? No☐ If yes, who ________

Previous consultation/treatment? Yes ☐ No☐ Patient☐ Orthodontist: ________ Mother☐ Father☐

Any injury of the face or teeth? Yes ☐ No☐ If yes...injury: ________

Oral Habits? (Past/Present) Yes ☐ No☐ Grinding☐ Clenching ☐ Tongue Thrusting ☐ Finger/Thumb Sucking ☐ Lip/Nail Biting ☐

Speech Problems? Yes ☐ No☐ Lisping☐ Had Speech Therapy ☐ Comments: ________

Musical Instruments/Sports? Yes ☐ No☐ Which instrument? ________ Which sports? ________

Any T.M.D. Symptoms (Joint)? Yes ☐ No☐ Clicking☐ Grinding☐ Joint Pain☐ Lock Open☐ Lock Close☐ Sore Muscles☐ Difficulty Chewing☐

Other Dental History? Yes ☐ No☐ Extractions☐ Canker Sores☐ Bleeding Gums☐ TMJ Treatment☐ Other: ________

Medical History SUMMARY

Patients family Physician: ________ Date of last visit ________

Allergies/Reactions? Yes ☐ No☐ Penicillin☐ Anesthetic☐ Aspirin☐ Advil☐ Latex☐ Metal☐ ________

Respiratory History? Yes ☐ No☐ Asthma☐ Hay Fever☐ Mouth Breathing☐ Frequent Sore Throat☐ ________

Head or Neck Pain? Yes ☐ No☐ Headaches☐ Ears☐ Eyes☐ Nose☐ Shoulder☐ Back☐ Neck Pain☐ Temple☐ ________

Heart Problems? Yes ☐ No☐ Murmur☐ Rheumatic fever☐ High blood pressure☐ ________

Operations/Hospitalizations? Yes ☐ No☐ For: Tonsils☐ Adenoids☐ ________

Use Of The Following? Yes ☐ No☐ Caffeine☐ Nicotine☐ Alcohol☐ Drugs☐ Past Substance Abuse☐ ________

Blood Disorders? Yes ☐ No☐ Bleed Easy☐ Hemophilia☐ Anemia☐ Leukemia☐ ________

Infectious Diseases? Yes ☐ No☐ Hepatitis☐ Tuberculosis☐ HIV+☐ AIDS☐ ARC☐ ________

Other Medical Problems? Yes ☐ No☐ Diabetes☐ Epilepsy☐ Mental☐ Emotional Disorders☐ Fainting Spells☐ ________

Medicate Before Appliance? Yes ☐ No☐ Antibiotics ☐ ________

Presently On Medication? Yes ☐ No☐ ________

Responsible Party

(If other than above) Name: ________ (LAST) (FIRST) Relationship: ________

Patient☐ Mother☐ Father☐ Other☐

Address: ________ (ZIP) SSN: ___-___-___

Employer/Occupation: ________ Phone: ________ Work Phone: ________

Orthodontic Insurance

May we copy your insurance card(s)? ☐ Yes

#1 Insurance Co. ________ Group #: ________ Employer: ________
Insured: ________ Insured # ________ SSN: ___-___-___ Birthday: __/__/__

#2 Insurance Co. ________ Group #: ________ Employer: ________
Insured: ________ Insured # ________ SSN: ________ Birthday: __/__/__

I have read and understand the above questions and that it is necessary to provide dental care in a safe and efficient manner. I will not hold Dr. Peavy or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. I have read and agreed to Dr. Peavy's consent for use and disclosure of health information.

I understand that, when appropriate, credit bureau reports may be obtained, and that by my signature below this disclosure I authorize such a report.

________ SIGNATURE OF RESPONSIBLE PERSON ________ DATE ________ DENTIST / STAFF ________ POSITION / DATE