Drs. Wood, Dunlevy & Lombardozzi
PEDIATRIC DENTISTRY & ORTHODONTICS

ACQUAINTANCE AND HISTORY QUESTIONNAIRE

Please present this questionnaire at the consultation appointment.

PATIENT

Patient's Name _____ Nickname _____

Today's Date _____ Birthdate _____ Sex _____ Age _____

Address _____ Zip _____ Phone _____

School _____ Grade _____ Interest _____

What is the child's attitude toward 1. School _____ 3. Dentistry _____

2. Brushing _____ 4. Orthodontics _____

Would you say the patient would cooperate fully in orthodontic treatment? _____

Has the patient been growing rapidly recently? _____ Is the patient a good, average, or fair student? (circle)

PARENTS

Father's Name _____

Address _____

Home Phone Number _____

S.S. Number _____

Occupation _____ How Long? _____

Place of Business _____

Business Phone _____

Mother's Name _____

Address _____

Home Phone Number _____

S.S. Number _____

Occupation _____ How Long? _____

Place of Business _____

Business Phone _____

Parents marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Who has custody of the child? _____ Number of children in family _____

Do other family members need orthodontic care? _____ Is the patient an adopted child? _____

ADULT PATIENT

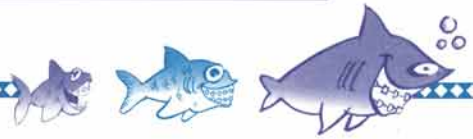
Occupation _____ Place of Business _____

Business Phone _____ How long employed there? _____

Spouse's Name _____ Occupation _____ How long employed there? _____

Place of Business _____ Business Phone _____

S.S. Number _____



MEDICAL HISTORY

Name and address of patient's physician _____

Present health: Good, Fair, Poor (circle) Date of last physical _____

Is patient now receiving medication? _____ If yes, for what? _____

Does the patient now have or has the patient had any of the following? (Check yes or no)

YES	NO		YES	NO		YES	NO	
_____	_____	Rheumatic Fever	_____	_____	Diabetes	_____	_____	Speech Problems
_____	_____	Heart Disease	_____	_____	Emotional Problems	_____	_____	Hearing Problems
_____	_____	Bleeding Problems	_____	_____	Mental Retardation	_____	_____	Tonsils Removed
_____	_____	Hepatitis	_____	_____	Drug Allergies	_____	_____	Sinusitis
_____	_____	A.I.D.S.	_____	_____	Frequent Colds	_____	_____	T.B.

4. Allergies _____ _____ If yes, list _____

5. Is your child taking any medication at this time? _____ _____ If yes, list _____

6. Is your child taking any Vitamins at this time? _____ _____ If yes, list _____

7. Has your child had any unfavorable reaction or allergy to medication, such as penicillin, aspirin or local anesthetic? _____ _____ If yes, list _____

8. Has your child ever been hospitalized? _____ _____ If yes, list _____

9. Date of last physical? _____

DENTAL HISTORY

Name and address of patient's general dentist _____

Has patient ever had a habit of sucking finger, thumb, or other? _____

How severe? _____ How long? _____ When? (nights only, etc.) _____

Has patient had previous orthodontic care? _____ If so, when? _____

For how long? _____ Treated by whom? _____

When did patient last see the dentist? _____ For what reason? _____

GENERAL INFORMATION

Who may we thank for referring you to this office? _____

What do you think is your/your child's biggest orthodontic problem? _____

Will payments be made by self, father, mother, or other? _____ Do you have dental insurance? _____

In separation or divorce situations, the individual who initiates services with us is held financially responsible.

Who do we contact in case of emergency? _____

_____

CONSENT: Your child is a minor. Therefore, it is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary orthodontic treatment can be started. Authorization is also necessary to release medical information to my physician if needed. Authorization is hereby granted as such.

I hereby certify that the information I have given is correct and true to the best of my knowledge. Furthermore, I give permission for the release of all information to any/all physicians, institutions or to any agency which may have an interest in the settlement of payments for services rendered. I further authorize direct payment to H.A. JACK DUNLEVY, D.M.D., M.S., I agree to pay my account as it comes due and further agree that if I do not, I will pay all the expenses incurred in collecting the same, including court costs and a 33.3% attorney's fee.

I agree that a service charge of 1 1/2% per month or (18% per annum) will be added to account over 60 days delinquent.

I agree to provide H.A. JACK DUNLEVY, D.M.D., M.S. with address and other information changes so that his office can properly send current bills to me.

Signed _____