Katie C. Julien, DDS MS APC
ORTHODONTIC ACQUAINTANCE CARD – CHILD

PATIENT'S NAME

First_____ MI_____ Last_____ Prefers to be called_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Birth Date:_____ Male____ Female____

School_____ Grade_____

FATHER'S NAME

First_____ MI_____ Last_____ Prefers to be called_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ SSN_____-_____-_____

Birth Date_____ Work Phone_____ Cell Phone_____

Employed by_____ Position_____Your Email_____

Insurance Company_____Group/ID #s _____Ins Phone_____

MOTHER'S NAME

First_____ MI_____ Last_____ Prefers to be called_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ SSN_____-_____-_____

Birth Date_____ Work Phone_____ Cell Phone_____

Employed by_____ Position_____Your Email_____

Insurance Company_____Group/ID #s _____Ins Phone_____

ORTHODONTIC HISTORY:

Were you referred to this office? _____ Name of person referring you_____

What motivated you to seek orthodontic care?_____

Have you consulted with an orthodontist previously?_____

Has your immediate family received treatment in our office?_____ If so, who? _____

What concerns you most about the thought of having braces? (appearance, cost, discomfort)_____

Nearest relative NOT residing in household?_____ Phone_____

Please continue on reverse side →

MEDICAL HISTORY: Physician's Name: _____

Are you in good health? Yes____ No____

Do you have or have you had any of the following diseases or problems?
___Rheumatic Fever
___Congenital heart problems
___Heart murmurs or heart surgeries
___Artificial heart valves
___Artificial joints
___Any condition that requires prophylaxis (antibiotics before dental procedures)
___Cardiovascular disease (heart attack, heart trouble, high blood pressure, stroke)
___Hepatitis – Type_____
___Hemophilia
___Diabetes
___Epilepsy/Convulsions
___Asthma – Controlled by_____
___Aids or HIV positive
List any other serious recurrent illnesses (physical or mental): _____
Are you or have you ever taken bisphosphonate drugs (such as Boniva, Fosamax, Actonel, etc.) No____ Yes____ Oral____ IV_____
List all prescriptions: _____

Allergic reactions? (including latex)_____ _____

BOYS: Has your voice changed? Yes____ No____ GIRLS: Have you begun menstruation? Yes____ No____

DENTAL HISTORY: Dentist's Name_____

Date of Last Cleaning/Check-Up_____

Have you had any of the following treatment:
___Periodontal treatment (gum treatment) How long ago?_____ Describe treatment_____
___Mouth guard or splint – For what purpose?_____
___Surgery to change your bite
Are you aware of any of the following?
___Sores, lumps or irritated areas in your mouth
___Food catching between your teeth
___Clenching or grinding your teeth
___Sore or bleeding gums
___Clicking, popping or grating noise in your jaw -- R_____ L_____ Both sides_____
___Have you had your tonsils/adenoids removed?
___Have you been a thumb-sucker? – Until what age?_____
___Have you been a mouth-breather?
___Have you been a lisper?
___Any unpleasant experiences at a dental office we should know about? If so, let us know.

The information I have given is correct and will be held in the strictest of confidence. I promise to be responsible for any charges that are incurred for the above-mentioned patient, and I authorize Dr. Katie C. Julien, DDS MS APC to evaluate and/or treat this patient.

Notice of Privacy Practices: Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information and of other important matters about your protected health information. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. You also have the right to request restrictions on the use of your protected health information. You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

***Signature of Responsible Party*_____ *Date*_____**