Smiles Hollywood Orthodontics™

Where Our Patients are the Stars!™

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Specialists in Orthodontics for Children & Adults

Date_________________

Acquaintance Record-Youth

Patient's Name ____ Sex ____________ Nickname______________________________

Age ___________________ Date of Birth _______________________ Weight __________ School ________________________________

List any hobbies, sports or school activities enjoyed: ____

List names & ages of any siblings: ____

How did you hear about our office? ____

Medical History/Information

Please indicate YES if the Patient currently has or has ever had any of the following medical conditions.

	Yes	No		Yes	No		Yes	No
Heart Disease?			Asthma or Hay Fever?			Nervous/Emotional Problems?		
Heart Murmur or Defect?			Tuberculosis?			High or Low Blood Pressure?		
Respiratory Disease?			Any Broken Bones?			Problems with Wound Healing?		
Blood Disease?			Prolonged Bleeding?			Chemotherapy?		
Liver Disease?			Yellow Jaundice?			Osteoporosis?		
Thyroid Disease?			Radiation Therapy?			Rheumatic/Scarlet Fever?		
Kidney Disease?			Mononucleosis?			Rheumatism or Arthritis?		
Venereal Disease?			Hepatitis?			Is Patient Currently Under Medical Care?		
Intestinal Disease?			Polio?			History of Fainting or Dizziness?		
Bone Disease?			Diabetes?			Presence of Drug / Alcohol Addiction?		
Endocrine Problems?			Anemia?			Is the Patient Pregnant at This Time?		
HIV Positive?			Hemophilia?			Does the Patient Smoke?		
Blood Transfusion?			Emphysema?			Has Patient Ever Had Fever Blisters?		
Tumors or Cancer?			Epilepsy or Seizures?			Is the Patient in Good Health?		

If Female, Has Menstruation Begun? Yes / No If Yes, When Did it Start?		
Is the Patient Allergic to Anything?	Yes	No
If Yes, Please list all allergies. (penicillin, latex, medicines, foods)		
Is the Patient Currently Taking Any Medications?	Yes	No
If Yes, Please list all medications.		
Are You Aware of Any Other Disease, Condition, or Disability Not Listed Above?	Yes	No
If Yes, Please list/explain.		
Dental History		
Patient's Dentist : Date Last Seen:		
Any Pain, Clicking or Discomfort In or Near the Ears? Yes / No Any Severe or Frequent Headaches?	Yes	No
Has/Have the Mouth, Face or Teeth Been Injured by a Fall or Accident?	Yes	No
Have You Been Informed of Missing or Extra Permanent Teeth?	Yes	No
Are You Aware of Any "Gum" Problems? Yes / No Has the Patient Had Any Periodontal "Gum" Treatment?	Yes	No
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?	Yes	No
Have the Patient's Tonsils or Adenoids Been Removed? Yes / No If Yes, When?		
Do You Feel the Patient Can Benefit From Orthodontic Treatment?	Yes	No
Does the Patient Want to Improve His/Her "Smile" and/or "Bite"?	Yes	No
Would the Patient mind wearing braces?	Yes	No
Has the Patient Been Examined by an Orthodontist Before? Yes / No If Yes, When?		
Have Other Family Members Had Orthodontic Treatment? Yes / No If Yes, Were you happy with results? If Not, Why?		
What Is Your Chief Orthodontic Concern for the Patient?		

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