YOUTH ACQUAINTANCE CARD

Michael L. Keim, D.D.S., P.C.
Orthodontist

DATE_____

PATIENT'S NAME _____ AGE_____YRS. _____MOS.
LAST FIRST MIDDLE INITIAL

NICKNAME _____ SEX_____ PH#_____ DATE OF BIRTH_____/_____/_____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

SCHOOL _____ GRADE _____ INTERESTS _____

FATHER_____ EMAIL _____ HOME# ( )_____

ADDRESS _____ CITY_____ STATE _____ ZIP _____ CELL# ( )_____

OCCUPATION _____ EMPLOYED BY _____ WORK# ( )_____

MOTHER_____ EMAIL _____ HOME# ( )_____

ADDRESS _____ CITY_____ STATE _____ ZIP _____ CELL# ( )_____

OCCUPATION _____ EMPLOYED BY _____ WORK# ( )_____

LIST ANY FRIENDS OR RELATIVES SEEN IN THIS OFFICE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PERSON(S) RESPONSIBLE FOR ACCOUNT _____DO YOU HAVE DENTAL INSURANCE?_____

PHYSICIAN'S NAME_____ CLINIC/CITY _____

CHECK (✓) ANY KNOWN HISTORY AND EXPLAIN BELOW:

_____ALLERGIES TO MEDICATIONS
_____ALLERGIES TO LATEX/NICKEL
_____DIABETES
_____EPILEPSY
_____EXCESSIVE BLEEDING
_____GENETIC DISORDERS
_____ARTHRITIS
_____HEART DISEASE
_____HEPATITIS
_____HIGH BLOOD PRESSURE
_____HIV INFECTION/AIDS
_____PSYCHIATRIC CARE
_____RHEUMATIC FEVER
_____SINUS PROBLEM
_____TONSILLITIS
_____TUBERCULOSIS

MAJOR ILLNESSES/OTHER MEDICAL INFORMATION _____

CURRENT MEDICATIONS: _____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES_____ NO_____ HAS PATIENT REACHED PUBERTY? YES_____ NO_____

DENTIST'S NAME_____

LAST DENTAL EXAM _____

HAVE YOU SEEN AN ORTHODONTIST PREVIOUSLY? YES_____ NO_____ IF SO, WHOM?_____ WHEN?_____

CHECK (✓) ANY OF THE APPROPRIATE DESCRIPTIONS OF PATIENT:

_____ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS
_____HISTORY OF THUMBSUCKING
_____BREATHING MOSTLY THROUGH MOUTH
_____LIPS APART AT REST
_____PERIODONTAL (GUM) PROBLEMS
_____EXTRA TEETH
_____MISSING PERMANENT TEETH
_____INJURED TEETH DUE TO FALL OR ACCIDENT
_____SEVERE HEAD OR FACE INJURY
_____FREQUENT HEADACHES
_____PAIN, CLICKING, OR POPPING OF JAWS OR EARS
_____LOCKING OR CATCHING OF JAW
_____GRINDING OR CLENCHING OF TEETH
_____OTHER

SIGNATURE OF PATIENT/RESPONSIBLE PARTY _____ DATE _____