NENAD B. STEFANOVIC, D.D.S., M.S.D., P.A.

ORTHODONTIC ACQUAINTANCE & HEALTH FORM

We would like to welcome you to Dr. Stefanovic's office. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime. To help us with your orthodontic evaluation, we ask that you completely answer all questions listed on this side of the form only.

Tell Us About Your Child

Patient's Name: _____ Age: _____
Last First MI Nickname

Date of Birth: ____ / ____ / ____ Home Phone#: _____ School: _____ Grade: _____

Address: _____

City: _____ State: _____ Zip: _____ ☐ Male ☐ Female

Ages of Brothers: ____ ____ ____ ____ Ages of sisters: ____ ____ ____ ____ Athletics: _____

Hobbies: _____ Musical Instruments: _____

Parent's Information

Mother's Name: _____ Home Phone#: _____

Employer: _____ Business Phone#: _____

Father's Name: _____ Home Phone#: _____

Employer: _____ Business Phone#: _____

Person Responsible For Account

Name: _____ Relation: _____

_____

City: _____ State: _____ Zip: _____ Home Phone #: _____

Work Phone #: _____ Social Security #: _____ Driver's License #: _____

Orthodontic Insurance? ☐Yes ☐No Insurance Co. Name: _____

Dental History

Dentist: _____ City: _____ Last Visit: _____

Are you presently under dentist's care? ☐Yes ☐No If yes, please explain _____

Do you have any pain now? ☐Yes ☐No If yes, please explain _____

Have you had a previous orthodontic consultation? ☐Yes ☐No With which doctor? _____

Has any family member had previous orthodontic treatment? ☐Yes ☐No With which doctor? _____

How did you hear about us? _____

What improvement would you like to see? _____

Do you have any of the following habits?

☐Yes	☐No	Thumb or Finger Sucking	☐Yes	☐No	Mouth Breathing	☐Yes	☐No	Nail Biting
☐Yes	☐No	Tongue Thrust	☐Yes	☐No	Cheek or Lip Biting	☐Yes	☐No	Grinding Teeth
☐Yes	☐No	Speech Problems	☐Yes	☐No	Brush Teeth Daily	☐Yes	☐No	Gum Chewing

Have you ever had any of the following?

☐Yes	☐No	Gum Disease	☐Yes	☐No	Bleeding Gums	☐Yes	☐No	Tooth Injury
☐Yes	☐No	Root Canal Treatment	☐Yes	☐No	Pain in Jaw Joint	☐Yes	☐No	Ear Aches
☐Yes	☐No	Teeth Removed	☐Yes	☐No	Injury to Head, Face, or Neck			
☐Yes	☐No	Clicking Noises in Jaw	☐Yes	☐No	Filling or Cavity Close to Nerve			

Medical History

Physician: _____ Last Exam: _____ General Health: _____

Are you presently under physician's care? ☐Yes ☐No If yes, please explain _____

Please list any medications currently being taken? _____ Any operations? _____

Do you have any history of the following?

☐Yes	☐No	Allergies to Medicine	☐Yes	☐No	Asthma	☐Yes	☐No	Blood Disease
☐Yes	☐No	Convulsions	☐Yes	☐No	Diabetes	☐Yes	☐No	Eye Disorders
☐Yes	☐No	Hepatitis/Liver Disease	☐Yes	☐No	HIV or AIDS Infection	☐Yes	☐No	Heart Disease
☐Yes	☐No	Kidney Disease	☐Yes	☐No	Muscle Coordination problems	☐Yes	☐No	Psychiatric Care
☐Yes	☐No	Rheumatic Fever	☐Yes	☐No	Stomach Problems			

Do you feel that your child will be cooperative during treatment? ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. X _____

Signature of Parent or Guardian