



BRENT HURST, D.D.S., M.S.

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ORTHODONTIC ACQUAINTANCE CARD

Date _____ 20 _____

Date of Birth _____

Patient's Name _____ Age _____ Sex _____
LAST FIRST

Address _____ Phone _____
CITY ZIP

Email Address _____

DENTAL HISTORY

- Have There Been Any Injuries To The Face, Mouth Or Teeth? Yes No
- Does The Patient Have Any Speech Problems? Yes No
- Is The Patient A Mouth Breather? While Awake? Yes No
- While Asleep? Yes No
- Have You Been Informed Of Any Missing Or Extra Teeth? Yes No
- Has An Orthodontist Been Consulted Previously? Yes No
- Have You Ever Had Jaw Problems? Yes No

Reason for Present Consultation _____

Patient's Dentist _____ Date of Recent Check-Up _____

Patient's Physician _____

MEDICAL HISTORY

- Is Patient In Good Health? Yes No
- Does Patient Have Any History Of Major Illness? Yes No
- Is Patient Under Care Of A Physician Now? Yes No

Please Specify _____

Has the patient had any of the following (please circle):

- | | | |
|-------------------|---------------------------|-----------------------|
| Anemia | Fainting Or Dizziness | Kidney Problems |
| Arthritis | Headaches | Lower Back Pain |
| Asthma | Heart Condition | Neckaches |
| Bleeding Problems | Hepatitis - Liver Disease | Nervous Disorders |
| Diabetes | High Blood Pressure | Psychiatric Treatment |
| Epilepsy | H.I.V. | Tuberculosis |

List Any Drugs Or Medications Now Being Taken, and Purpose _____

Have Tonsils And Adenoids Been Removed?..... Yes No

List Any Allergies Or Drug Sensitivity _____

Family History (optional) Biological Parents Step Parents Adoptive Parents

Please indicate outside interests and hobbies _____

Arthur

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle Relationship to Patient

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____