TIMOTHY SHAUGHNESSY, D.D.S., M.S.

Welcome To Our Office

ORTHODONTIC ACQUAINTANCE CARD DATE________

-Please Print-

Email______________________________________ Date of Birth________________

Patient's Name____ Age________ Sex: Male ☐ Female ☐
First Middle Last

Name Patient Prefers To Be Called______________________________ Cellphone__________________

Address____ Telephone__________________
Street City State Zip

School____________________________ Grade________ Last Visit to Dentist__________________

Patient's Hobbies or Interests____________________________ Name of Dentist__________________

Whom may we thank for referring you?____

Father's Name________________________________ Occupation__________________

Employed by________________________________ Business Telephone__________________

Business Address____________________________________ Soc Sec No__________________

Mother'sName________________________________ Occupation__________________

Employed by________________________________ Business Telephone__________________

Business Address____________________________________ Soc Sec No__________________

Name Of Person Responsible For Account________________________ Email__________________

Relationship to Patient____

Names and Ages of Other Children in Family____

Do you have dental insurance that covers orthodontic treatment? Yes ☐ No ☐

Name Of Insurance Company________________________ Claims Address & Phone__________________

Subscriber's Name__________________ Subscriber's DOB__________ Group #__________ ID#__________

Is the patient under the care of a physician for a specific problem at the present time? Yes ☐ No ☐ Ilness__________________

List any medicines your child is currently taking____

List any drug sensitivities____

Is there a history of serious illness, accident or operation?____

If so, list____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

☐ Contact Lenses	☐ High Blood Pressure	☐ Allergies or Asthma	☐ Speech Problems
☐ Glaucoma	☐ Head or Facial Injury	☐ Rheumatic Fever	☐ Emotional Problems
☐ Heart Trouble	☐ Tonsillitis	☐ Diabetes	☐ Endocrine Problems
☐ Kidney Disease	☐ Hearing Disorder	☐ Bleeding Problems	☐ Nervous Disorder
☐ Hepatitis/Liver Disease	☐ Ear Infections	☐ Epilepsy	☐ Adopted

Has the patient reached puberty?

Girl: Has she started menstruation? Yes ☐ No ☐ If yes, Month/Year__________________

Boys: Secondary Sex Characteristics: Hair Development? Yes ☐ No ☐ Has voice changed? Yes ☐ No ☐

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth?__________________ Yes ☐ No ☐

Has the patient ever sucked thumb or fingers?__________________ Yes ☐ No ☐

Until what age?__________

Has an orthodontist been consulted previously? __________________ Yes ☐ No ☐

Has the patient had any previous orthodontic treatment?__________________ Yes ☐ No ☐

If so, by whom? __________________

Have you been informed of any missing or extra permanent teeth?__________________ Yes ☐ No ☐

Has either parent had orthodontic treatment?__________________ Yes ☐ No ☐

Please list any family members previously treated here____

What part of your child's orthodontic problem concerns you most?____

____

____

Additional information which you feel would help make your child's association with us more enjoyable__________________

____

Member
American Association of
Orthodontists

THANK YOU

____
Signature of Parent or Gaurdian