David L. Sparks, D.D.S.
ORTHODONTIST

CALIFORNIA TIN GRIN

DEPENDENT ORTHODONTIC ACQUAINTANCE CARD

Date _____ 20 _____ Date of Birth _____

Patient's Name _____ School _____ Age _____ Sex _____

Address _____ Home Phone ( ) _____

City _____ Zip _____ How long at this address? _____

Patient's Dentist _____ Phone ( ) _____ City _____

Who may we thank for sending you to us? _____

Father _____ Birthday _____	Mother _____ Birthday _____
Address _____	Address _____
City _____ Zip _____	City _____ Zip _____
Home Phone _____ Cell ( ) _____	Home Phone _____ Cell ( ) _____
Employer _____	Employer _____
Job Title _____	Job Title _____
Bus. Phone ( ) _____ Ext. _____	Bus. Phone ( ) _____ Ext. _____
Soc. Sec. No. _____	Soc. Sec. No. _____
Father's Dental Ins. Co. _____	Mother's Dental Ins. Co. _____
Father's Ins. Co. Phone ( ) _____	Mother's Ins. Co. Phone ( ) _____

Person Responsible for Account _____ Soc. Sec. No. _____

Person Responsible Email _____

List hobbies or interests of patient _____

In the following questions, circle yes or no, whichever applies:

1. Is patient in good health? ..... YES NO
2. Has there been any change in patients general health within the past year? ..... YES NO
3. Patient's last physical examination was on _____
4. Is patient now under the care of a physician? ..... YES NO
5. The name of patient's physician _____
   address _____
   city & phone _____
6. Has patient been hospitalized or had a serious illness within the past five (5) years? (please explain) ..... YES NO
   a. Rheumatic fever or rheumatic heart disease ..... YES NO
   b. Congenital heart lesions ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary, insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES NO
      1. Does patient have pain in their chest upon exertion? ..... YES NO
      2. Is patient ever short of breath after mild exercise? ..... YES NO
      3. Does patient's ankles swell? ..... YES NO
      4. Is patient short of breath when they lie down, or do they require extra pillows when they sleep? ..... YES NO
      5. Does patient have a cardiac pacemaker? ..... YES NO
   d. Sinus trouble ..... YES NO
   e. Asthma or hay fever ..... YES NO
   f. Hives or a skin rash ..... YES NO
   g. Fainting spells, seizures or epilepsy (Please Circle) ..... YES NO
   h. Diabetes ..... YES NO
      1. Does patient have to urinate more than six times a day? ..... YES NO
      2. Is patient thirsty much of the time? ..... YES NO
      3. Does their mouth become frequently dry? ..... YES NO
   i. Jaundice, liver disease, hepatitis, or a carrier of hepatitis? (Please Circle) ..... YES NO
   j. Arthritis ..... YES NO
   k. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   l. Stomach ulcers ..... YES NO
   m. Kidney trouble ..... YES NO
   n. Tuberculosis ..... YES NO
   o. Does patient have a persistent cough or cough up blood? ..... YES NO

(over)

p. Venereal disease (Specify) ..... YES NO
q. HIV or ARC (Specify) ..... YES NO

7. Has patient had abnormal bleeding associated with previous extractions, surgery or trauma? ..... YES NO
   a. Does patient bruise easily? ..... YES NO
   b. Has patient ever required a blood transfusion? ..... YES NO
      If so, explain circumstances _____
8. Does patient have any blood disorder, such as anemia? ..... YES NO
9. Has patient had surgery or x-ray treatment for a tumor, growth, or other condition of the head or neck? ..... YES NO
10. Is patient taking any drug or medicine? ..... YES NO
    If so, what? _____
11. Is patient allergic or have they reacted adversely to:?
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics (Specify) _____ YES NO
    c. Sulfa drugs ..... YES NO
    d. Latex ..... YES NO
    e. Aspirin ..... YES NO
    f. Codeine or other narcotics (Specify) _____ YES NO
    g. Other (Specify) _____ YES NO
12. Has patient had any serious trouble associated with any previous dental treatment? ..... YES NO
    If so, explain _____
13. Does patient require antibiotics before dental procedures? ..... YES NO
14. Is patient employed in a any situation which exposes them regularly to x-rays or other ionizing radiation? ..... YES NO
    If so, explain _____
15. Have tonsils and adenoids been removed? at what age? _____ ..... YES NO
16. For growth prediction in girls: Have menstrual cycles started? at what age? _____ ..... YES NO
17. Is there any medical condition or serious illness, past or present that we should know about? ..... YES NO
    a. If yes, explain _____

DENTAL HISTORY

1. Has the patient ever sucked a thumb or fingers? Until what age? _____ ..... YES NO
2. Has the patient had tongue-thrust or speech therapy? ..... YES NO
3. Has there been any injuries to the face, mouth or teeth? ..... YES NO
4. Does the patient's jaw ever hurt? ..... YES NO
5. Does the patient's jaw ever pop or crack when opening? ..... YES NO
6. Has the patient's jaw ever locked open or closed? ..... YES NO
7. Does the patient have any speech problems? ..... YES NO
8. Is the patient a mouth breather? ..... YES NO
9. Has an orthodontist been consulted previously? Who? _____ ..... YES NO
10. Has any family member had orthodontic treatment? ..... YES NO
11. When was last dental care? _____
12. What do you want orthodontic treatment to accomplish? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

_____ _____

Signature Date

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____ _____

Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

(_____)

Dr.