BRUNO ORTHODONTICS
CREATING BEAUTIFUL SMILES

CHILD ORTHODONTIC ACQUAINTANCE FORM

Richard A. Bruno, D.D.S., M.S., P.C.
730 N. Crooks
Clawson, MI 48017
248-435-2000

Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: (home) (cell) (work): _____ Relationship to patient: _____
Please circle

Mom's Email Address: _____ Dad's Email Address: _____

Family Dentist: _____ Address: _____ Phone: _____

Family Physician: _____ Address: _____ Phone: _____

School: _____ City: _____ Grade: _____ Phone: _____

Sports, Special interests: _____

Siblings: Name: _____ DOB: _____ Name: _____ DOB:_____

Name: _____ DOB: _____ Name: _____ DOB: _____

Family members with similar conditions: _____

Family members who have had orthodontic treatment: _____

Have you seen another orthodontist? ☐ Yes ☐ No If yes, Name:_____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

PARENT INFORMATION

Parents Living Together: ☐ Yes ☐ No Divorced: ☐ Yes ☐ No Father Deceased: ☐ Yes ☐ No

Child Lives With: _____ Separated: ☐ Yes ☐ No Mother Deceased: ☐ Yes ☐ No

Father's Name: _____ Date of Birth: _____ Ethnic Background: _____

Phone: (home) (cell) (work) _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Address: _____

Dental Insurance Carrier: _____ Orthodontic Insurance: ☐ Yes ☐ No

Mother's Name: _____ Date of Birth: _____ Ethnic Background: _____

Phone: (home) (cell) (work) _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ Address: _____

Dental Insurance Carrier: _____ Orthodontic Insurance: ☐ Yes ☐ No

Financially Responsible Party: _____

American Association of Orthodontists

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MEDICAL HISTORY

General Health Status: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Birth Defects: _____

Presently under medical care for: _____

Drugs or medication currently being taken (Drug and Dosage): _____

Allergic to what drugs: _____ Latex Allergy: ❑ Yes ❑ No

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING ITEMS AND DATE EACH

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
Adenoids removed	❑	❑	_____	Heart disorder	❑	❑	_____	Congenital heart disease	❑	❑	_____	Hearing difficulties	❑	❑	_____
AIDS	❑	❑	_____	Hepatitis	❑	❑	_____					Neurosis	❑	❑	_____
Allergies	❑	❑	_____	Hospitalized	❑	❑	_____	Convulsions	❑	❑	_____	Polio	❑	❑	_____
Anemia	❑	❑	_____	Hyperactivity	❑	❑	_____	Diabetes	❑	❑	_____	Rheumatic Fever	❑	❑	_____
Arthritis	❑	❑	_____	Hypertension	❑	❑	_____	Dizziness	❑	❑	_____	Scoliosis	❑	❑	_____
Asthma	❑	❑	_____	Injuries	❑	❑	_____	Emotional	❑	❑	_____	Seizures	❑	❑	_____
Blood disorder	❑	❑	_____	Jaundice	❑	❑	_____	Endocrine disorder	❑	❑	_____	Speech difficulties	❑	❑	_____
Bone disorder	❑	❑	_____	Kidney disorder	❑	❑	_____	Epilepsy	❑	❑	_____	X-ray treatment (i.e. radiation treatment)	❑	❑	_____
Breathing difficulties	❑	❑	_____	Liver disorder	❑	❑	_____	Epistaxis (nosebleed)	❑	❑	_____				
Bronchitis	❑	❑	_____	Lung disorder	❑	❑	_____	Eye disorders	❑	❑	_____	Tonsils (removed)	❑	❑	_____
Chicken Pox	❑	❑	_____	Measles	❑	❑	_____	Fainting spells	❑	❑	_____	Tuberculosis	❑	❑	_____
Cerebral Palsy	❑	❑	_____	Mumps	❑	❑	_____	Glaucoma	❑	❑	_____	Venereal disease	❑	❑	_____

Other: _____

Please give greater details to any above "yes" responses: _____

_____

SEXUAL MATURATION

The following information is needed to help determine the patient's growth potential or cessation of growth

Female patients: Monthly periods: ❑ Yes ❑ No Started at age: _____ years _____months

Other indications of pubertal development: _____

Male patients: Voice change: ❑ Yes ❑ No Facial hair growth: ❑ Yes ❑ No

Other indications of pubertal development: _____

DENTAL HISTORY

Date of last dental check-up:_____ Does water in your area contain fluoride? ❑ Yes ❑ No

Injuries or trauma to the face or teeth: _____

How often does the patient brush his/her teeth each day? _____ Does patient floss regularly? ❑ Yes ❑ No

Does the patient play a musical instrument? ❑ Yes ❑ No If yes, which instrument:_____

Thumb sucking: ❑ Yes ❑ No Discontinued at age: _____

Other habits (lip biting, nail biting), Specify:_____

Breathing: ❑ Nose ❑ Mouth Difficulty at night? ❑ Yes ❑ No

Mouth posture: ❑ Usually open ❑ Frequently open ❑ Seldom open

Present infections: ❑ None ❑ Ear ❑ Nose ❑ Throat Specify:_____

Grinds teeth: ❑ Yes ❑ No At night? ___ Daytime? ___

WHY ARE YOU SEEKING ORTHODONTIC TREATMENT? _____

_____

To the best of my knowledge, the above statements are complete and correct. No information has been omitted or withheld.

Questionnaire completed by: _____ Date:_____

Relation to patient: _____