Dr. Brian N. Laski
Dr. Stacey J. Kirshenblatt
Certified Specialists in Orthodontics
and Dentofacial Orthopaedics

Child Orthodontic Acquaintance Form

Patient's Name: _____ Email: _____
Date of Birth: ___DD ___MM _____YY Age: _____ Sex: ____ School:_____ Grade: _____
Home Address: _____ City: _____ Postal Code: _____
Number of children in the family: _____ Ages & names of other children: _____
Patients Dentist: _____ Who may we thank for referring you?_____
Physician:_____ Physicians Tel:_____
Parent/Guardian Name:_____ Home Tel:_____ Daytime Tel: _____
Parent/Guardian Name: _____ Home Tel:_____Daytime Tel: _____
Person responsible for account: _____
Do you have an insurance plan that covers orthodontic treatment? _____

MEDICAL HISTORY – HAS THE CHILD BEEN TREATED FOR ANY OF THE FOLLOWING?

□ Rheumatic Fever	□ Asthma	□ ADD / ADHD
□ Heart Murmur / Heart Defect	□ Kidney Disorder	□ Learning / Behavioural Condition
□ Artificial Heart Valve	□ Prolonged Bleeding	□ Autism Spectrum
□ Hepatitis A, B, or C	□ Kidney Disorder	□ Psychiatric Disorders
□ Tuberculosis	□ Liver Disease	□ Other _____
□ H.I.V. / A.I.D.S.	□ Leukemia / Cancer	□ **None of the Above**
□ Diabetes		

If you checked off any of the above, please give pertinent details: _____
Is the child being treated for any other medical conditions? _____
List any drugs or medications being taken (Please give reason): _____
Does the child have any history of major illness and/or operations? _____
List any allergies or drug sensitivities: _____
Have tonsils or adenoids been removed? If so at what age? _____
Does the child have a tendency to colds, sore throats or ear infections? (Please list) _____

DENTAL HISTORY – Please circle

Has the child ever been treated for a jaw joint problem, including surgery?	Yes/No	
Have there been any injuries to the face, mouth or teeth? Please describe?	Yes/No	_____
Has the child ever sucked his/her thumb or finger? If so until what age?	Yes/No	_____
Does the child have any speech problems?	Yes/No	
Does the child get frequent canker or cold sores?	Yes/No	
Is the child a mouth breather?	Yes/No	Asleep/Awake
Have you been informed of any missing or extra permanent teeth?	Yes/No	
Is the child especially apprehensive towards dental visits?	Yes/No	

Please name any family members treated in our office: _____
When did the child last see the family dentist? _____
List any sports, hobbies or musical instruments played: _____
Reason for orthodontic consultation? _____
Has the child ever had a previous orthodontic examination or treatment? If so when?_____

I hereby give Dr. Brian Laski and/or Dr. Stacey Kirshenblatt and/or members of their staff permission to release information concerning my dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertain to the initial condition, diagnosis, proposed treatment plan or treatment in progress.
I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for clinical examination.

_____ _____
Signature of Parent or Legal Guardian Date