ORTHODONTIC ACQUAINTANCE CARD

DATE _____ 20____

PATIENT'S NAME _____ AGE _____ SEX _____
FIRST M.I. LAST

PREFERRED NAME (NICK NAME) _____ DATE OF BIRTH _____ PHONE( )_____

PATIENT'S ADDRESS _____ CITY _____ ZIP CODE _____

PATIENT'S DENTIST _____PHYSICIAN _____REFERRED BY_____

NUMBER OF SIBLINGS _____ NAMES/ DATES OF BIRTH _____

_____

FATHER / GUARDIAN / SELF _____HOME PHONE( )_____

ADDRESS _____ CITY _____ ZIP CODE_____

E-MAIL ADDRESS _____CELL PHONE( )_____

EMPLOYER _____CITY _____WK PHONE ( )_____

MOTHER / SPOUSE_____HOME PHONE( )_____

ADDRESS _____ CITY _____ ZIP CODE_____

E-MAIL ADDRESS _____CELL PHONE( )_____

EMPLOYER _____CITY _____WK PHONE ( )_____

DO YOU HAVE INSURANCE THAT COVERS A PORTION OF ORTHODONTIC TREATMENT? YES ❑ NO ❑

see page 2

MEDICAL HISTORY

Check any of the following for which the patient has been treated:

Diabetes ❑	Tuberculosis ❑	Endocrine ❑
Pneumonia ❑	Anemia ❑	Prolonged Bleeding ❑
Heart Trouble ❑	Epilepsy ❑	Liver Involvement ❑
Pacemaker / Heart valve implant ❑	Asthma ❑	Fainting & Dizziness ❑
Rheumatic Fever ❑	Kidney Involvement ❑	Nervous Disorders ❑
Bone Disorders ❑	Artificial joints / prosthesis ❑	Positive test for hepatitis ❑

IS THE PATIENT IN OVERALL GOOD HEALTH? _____ YES ❑ ❑ NO

DOES THE PATIENT HAVE ANY HISTORY OF A MAJOR ILLNESS? IF SO, PLEASE EXPLAIN._____ _YES ❑ ❑NO

_____

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS _____

_____

IS THERE A PAST OR CURRENT USE OF THE FOLLOWING MEDICATIONS:

FOSAMAX (ALENDRONATE SODIUM) ❑ Yes ❑ No ZOMETA (ZOLEDRONIC ACID) ❑ Yes ❑ No BONIVA (IBANDRONATE SODIUM) ❑ Yes ❑ No

AREDIA (PAMIDRONATE DISODIUM) ❑ Yes ❑ No ACTONEL (RISEDRONATE SODIUM) ❑ Yes ❑ No RECLAST (ZOLEDRONIC ACID) ❑ Yes ❑ No

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

DOES THE PATIENT HAVE TENDENCY TO HAVE EAR INFECTIONS ?_____ YES ❑ ❑ NO

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ YES ❑ ❑ NO

ORTHODONTIST
GEORGE G. HARTL, D.D.S., M.S. **1305 W. CHESTNUT, WEST BEND, WI 53095** **PHONE (262) 334-2361**
HARTL ORTHODONTICS, LLC **drghartl@sbcglobal.net** **FAX (262) 334-1664**

see page 2

DENTAL HISTORY

HAVE ANY WISDOM TEETH BEEN REMOVED? HOW MANY? _____ YES ❑ ❑ NO

HAVE THERE BEEN ANY INJURIES TO THE FACE OR TEETH _____ YES ❑ ❑ NO

HAS THERE BEEN ANY PROBLEM WITH THE JAW JOINTS? IF SO, PLEASE EXPLAIN. _____ YES ❑ ❑ NO

_____

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? YES ❑ ❑ NO UNTIL WHAT AGE? _____

DOES THE PATIENT HAVE ANY PROBLEMS WITH SPEECH OR SWALLOWING?_____ YES ❑ ❑ NO

HAVE YOU EVER NOTICED IF THE PATIENT IS A MOUTH BREATHER? } WHILE AWAKE? _____ YES ❑ ❑ NO

WHILE ASLEEP? _____ YES ❑ ❑ NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ YES ❑ ❑ NO

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAMINATION? _____ YES ❑ ❑ NO

HAVE THE PARENTS OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT? _____ YES ❑ ❑ NO

IS THE PATIENT MOTIVATED ABOUT ORTHODONTIC TREATMENT? _____ YES ❑ ❑ NO

MONTH OF LAST DENTAL VISIT _____

LIST ANY MUSICAL INSTRUMENTS THAT YOU PLAY _____

PLEASE LIST SPORTS AND HOBBIES _____

REASON FOR ORTHODONTIC CONSULTATION _____

ADDITIONAL COMMENTS _____

_____

ORTHODONTIC INSURANCE INFORMATION

INSURANCE CO. #1

Name of Insurance Co._____

Address_____

City _____ State _____ Zip_____

Name of Policy Holder _____ B.D. _____

Name of Employer _____

City _____

Group # or Policy/Plan # _____

I.D. # or SS# _____

Ins. Co. Phone # _____

INSURANCE CO. #2

Name of Insurance Co._____

Address_____

City _____ State _____ Zip_____

Name of Policy Holder _____ B.D. _____

Name of Employer _____

City _____

Group # or Policy/Plan # _____

I.D. # or SS# _____

Ins. Co. Phone # _____

INSURANCE AGREEMENT

This office cooperates with individuals who are covered by insurance. Please provide us with complete dental insurance information. We ask that you read your policy carefully to ensure that you are fully aware of any limitations of benefits. You should look upon your insurance realistically, as a device which helps in reimbursement for expenses. It is your company. We will assist you by completing all forms pertaining to your claim.

Your policy may base its allowances on a fixed fee schedule which may or may not coincide with our usual fees. Our practice is committed to providing the best treatment possible for our patients. Our fees are usual and customary for our area.

Patient's or Authorized Person's Signature, for insurance.

I authorize the release of any medical information necessary to process insurance claims.

Signed _____ Date_____