HENRY J. UDOUJ III, DDS, MS

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GET ACQUAINTED FORM (Please complete)

Date _____

PATIENT INFORMATION

LAST NAME	FIRST	PREFERRED	SEX	DOB	AGE

ADDRESS (Number & Street)	CITY	STATE	ZIP	PHONE

SCHOOL (if student)	GRADE	EMPLOYED BY	BUS. PHONE

REFERRED BY ☐ Self ☐ Family Dentist_____
☐ Friend _____ ☐ Website ☐ TV/Billboard
☐ Other _____

NAME OF FAMILY DENTIST

SSN OF PATIENT

PRIMARY RESPONSIBLE PARTY

Name: _____

DOB: _____

Relationship to Patient: _____

Social Security #: _____

❑ *Check if address is same as patient address at top of page*

Address: _____

Phone: _____ TYPE: cell / home / work

Phone: _____ TYPE: cell / home / work

Marital Status: _____

e-mail: _____

Employer: _____

Position: _____

Please complete the following if applicable:

Spouse Name: _____

DOB: _____

Relationship to Patient: _____

Phone: _____ TYPE: cell / home / work

Phone: _____ TYPE: cell / home / work

e-mail: _____

Employer: _____

Position: _____

PRIMARY ORTHODONTIC INSURANCE

Policyholder Name: _____

Insurance Company _____

Employer: _____

Policyholder DOB: _____

Policyholder SSN: _____

Insurance ID #: _____

SECONDARY ORTHODONTIC INSURANCE

Policyholder Name: _____

Insurance Company _____

Employer: _____

Policyholder DOB: _____

Policyholder SSN: _____

Insurance ID #: _____

EMERGENCY CONTACT INFORMATION

Nearest relative/friend not living with you: _____

Relationship to patient: _____ Phone Number: _____

Please Complete Back Side

MEDICAL HISTORY QUESTIONNAIRE

Please check all that apply to patient.

- ❑ Self conscious about teeth/smile
- ❑ Brush daily
- ❑ Learning disability
- ❑ Had a previous orthodontic evaluation
- ❑ Chipped/injured tooth/teeth
- ❑ Teeth sensitive to hot/cold
- ❑ Jaw fractures/cysts/mouth infections
- ❑ Bleeding gums/bad taste/mouth odor
- ❑ Thumb/finger habit (until age:)
- ❑ Abnormal swallowing habit (tongue thrust)
- ❑ Mouth breathing/snoring
- ❑ Relative with similar tooth/jaw relationship
- ❑ TMJ (temporomandibular joint) dysfunction
- ❑ Adenoids and/or tonsils removed (at age:)
- ❑ Tobacco use
- ❑ Hepatitis A/B/C
- ❑ AIDS or HIV positive
- ❑ Anorexia/bulimia
- ❑ Allergy to nickel/latex/plastic/dental anesthetic
- ❑ Bone fractures/major accidents
- ❑ Rheumatoid or arthritic diagnosis
- ❑ Endocrine/thyroid condition
- ❑ Kidney condition
- ❑ Diabetes
- ❑ Cancer/tumor/radiation/chemotherapy
- ❑ Stomach ulcer/hyperacidity
- ❑ Polio/mononucleosis/TB/pneumonia
- ❑ Compromised immune system
- ❑ Bleeding disorder/bruising tendencies
- ❑ Anemia
- ❑ High or low blood pressure
- ❑ Cardiovascular condition
- ❑ Frequent headaches/colds/sore throat
- ❑ Eye/ear/nose/throat condition
- ❑ Menstruation has begun
- ❑ Pregnant/may be pregnant

Further explanation of any of the above: _____

_____

Other pertinent medical or dental information: _____

Medications currently being taken: _____

List any hobbies; musical instruments, sports, etc... _____

What would you like orthodontic treatment to accomplish? _____

Primary care physician name: _____ Phone number: _____

I understand that if office payment plans are offered, credit reports may be obtained.

I have read and understand the above questions. I will not hold Dr. Henry Udouj, III, DDS, MS or any member of their staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the aforementioned patient history record or medical/dental status, I will so inform Udouj Orthodontics.

Patient Signature: _____ **Date:** _____

Signature of Patient or of Parent or Guardian if Patient is a Minor