# Orthodontic Acquaintance Card - Child

Patient Name________________________________Nickname___________________________

Date of Birth_______/______/________Age__________M or F ___________

Home Address_________________________________________________Apt _______

City___________________________State_______Zip___________

Home Phone_(_______)_______________Email_______________________________________

Patient's School___________________________________________Grade________

Referred by________________________________Have you seen another orthodontist? ☐Y☐ N

Patient's Dentist________________________Patient's Physician________________________

## Parent Information

Mother's Name___________________________________________

Work Phone_(_______)_________________Cell Phone (_______)______________

Home phone (if different from patient) (________)____________________

Address (if different from patient)_____________________________________________

City____________________________State______Zip___________

Father's Name___________________________________________

Work Phone_(________)_________________Cell Phone (_______)_______________

Home Phone (if different from patient) (________)____________________

Address (if different from patient)_____________________________________________

City____________________________State______Zip___________

**Insurance Information:**

Person or Persons Responsible for Account_______________________________________

Home Phone_(_________)_________________________

Address if Different from Patient__________________________________________________

City________________________________State_______Zip____________

Dental Insurance Carrier______________________________________________

Does your insurer provide orthodontic coverage? ☐Y ☐ N ☐Unsure

Subscribers Name ____________________________________________________

Subscribers Social Security #____________________________________________

Subscribers DOB_______________________________________________________

Insurance ID #_________________________________________________________

Insurance Group #______________________________________________________

Employer_____________________________________________________________

Employer Address______________________________________________________

City________________________________State_________Zip__________________

**Miscellaneous:**

Have we seen any other members of your family?

Name(s): ________________________________________________________________________________

What is the patient's attitude toward receiving orthodontic treatment? _________________________

Would you think the patient's cooperation would be: ☐Excellent ☐Good ☐Fair ☐Poor?

MULLEN ORTHODONTICS
S. RUSSELL MULLEN DDS, MS
DIPLOMATE, AMERICAN BOARD OF ORTHODONTICS
(703) 771-9887 www.mullenortho.com

# Medical History

Patient Name: ________________________________________________

Is the patient in good health? ☐Y ☐N If no, explain__________________________

Does the patient have any history of major illness? ☐Y ☐N If yes, explain_____________

____________________________________________________________

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

| | | |
|---|---|---|
| __ADD/ADHD | __Fainting or dizziness | __Transplants |
| __AIDS/HIV | __Heart murmur | __Artificial joints |
| __Asthma | __Heart disease | __Other_____________ |
| __Artificial Heart valve | __Hepatitis type: _____ | _____________ |
| __Bone disorders | __Kidney disease | _____________ |
| __Bleeding abnormality | __Learning disability | _____________ |
| __Blood disease | __Liver disease | _____________ |
| __Cancer | __Nervous disorder | |
| __Chemical dependency | __Pneumonia | |
| __Diabetes | __Prolonged bleeding | |
| __Endocrine problems | __Rheumatic fever | |
| __Epilepsy | __Tuberculosis | |

Please list any **surgeries**/hospitalizations that the patient has had__________________

____________________________________________________________

Please list any **allergies** to food or medication:________________________________

____________________________________________________________

Is the patient allergic to latex? ☐Y ☐N Is the patient allergic to nickel? ☐Y ☐N

Does the patient have trouble wearing jewelry? ☐Y ☐N

Please list any **medications** the patient is taking currently__________________________

____________________________________________________________

Women Only: Are you pregnant? ☐Y ☐N Are you nursing? ☐Y ☐N

**Dental History**

Who is the patient's dentist?________________________________________

When was the patient's last dental appointment?______________________________

Please describe any injuries to the face, mouth, or teeth the patient has had______________

____________________________________________________________

Has the patient ever sucked a thumb or fingers? ☐Y ☐N Until what age?________

Does the patient still suck a thumb or fingers? ☐Y ☐N

Does the patient breathe through his/her mouth while awake? ☐Y ☐N

Does the patient breathe through his/her mouth while asleep? ☐Y ☐N

Have you been informed that the patient has any missing or extra teeth? ☐Y ☐N

______________________________ ______________

Signature of Patient or responsible party Date

Dr. Mullen's comments:______________________________________________

## Acknowledgement of Receipt of Notice of Privacy Practices

***You may refuse to sign this acknowledgement***

I ________________________________________________ have received a copy of this office's Notice of Privacy Practices.

______________________________________________
Name

______________________________________________
Signature

______________________________________________
Date

### For Office Use Only

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited us from obtaining acknowledgement

☐ Other (please specify)

______________________________________________

______________________________________________

______________________________________________
Employee Signature

# Photo Permission Form

## This form must be filled out.

I hereby give Mullen Orthodontics permission to photograph and use my or my minor child's photo for their website, Facebook page and within the Mullen Orthodontics office for promotional purposes.

I understand that I, or my minor child (under age 18), will not receive compensation for the use of this likeness in any form.

Please check below for permission:

- ❑ Mullen Orthodontics Facebook Page Permission
- ❑ Mullen Orthodontics Website Permission
- ❑ Mullen Orthodontics office walls
- ❑ All of the above
- ❑ None of the above

______________________________
Patient Name

______________________________
Name of Parent/Guardian (if applicable)

______________________________
Signature of Patient/Parent Guardian

______________________________
Date