FRED W. SALVATORIELLO DMD P.A.
Specialist in Orthodontics and Dento-Facial Orthopedics
800.SAY.SMILE

ORTHODONTIC ACQUAINTANCE CHART

Patient's Name_____ Birth Date: _____ Age:_____ SS#:_____
Husband's Name/Father's Name:_____ Employed By:_____
Wife's Name/Mother's Name:_____ Home Phone:_____
Home Address:_____ Business Phone:_____
Street City Zip

Dentist:_____ Date Last Examined:_____
Name, Address and Phone of Person financially responsible for the patient:_____
Relationship

How did you hear about our office? _____
School:_____ Grade:_____ Name, Age &_____
Number of Children in family_____
_____

MEDICAL AND DENTAL HISTORY (Circle appropriate answer and fill in the blanks where necessary)

Is patient in good health?.....	Yes	No
Have tonsils and/or adenoids been removed? At what age?.....	Yes	No
Has the patient reached puberty?.....	Yes	No
Do you consider the patient's height and weight normal for age?.....	Yes	No
Any history of major illness? If yes, list_____	Yes	No
Any allergies or drug sensitivity? If yes, list_____	Yes	No
Any medication now being taken? If yes, list_____	Yes	No
Is patient under medical care now? Reason_____	Yes	No

Circle if a problem: ear infection sore throats nasal congestion
Circle any of the following for which the patient has been treated:
Diabetes Arthritis Heart Problems Tonsilitis Endocrine Problems
Asthma Epilepsy Brain Injury Rheumatic Fever Nervous Disorders

Has patient had pervious orthodontic treatment?	None	Some	Considerable		
Is there a similar orthodontic problem in the family?	None	Father	Mother	Sibling	
Was it treated?.....				Yes	No
How successful was treatment?	Good	Fair	Poor		
Patient's general development resemble:	Neither Parent	Father	Mother	Yes	No
Does patient have any congenital abnormalities?	None	Cleft Lip +/or Palate		Yes	No
Was a pacifier used?.....				Yes	No
How was the patient nursed?	Breast	Bottle			

Has there been any injuries to the face, mouth or teeth?..... Yes No

Circle any past or present habits: thumb sucking finger sucking lip biting or tongue thrusting
Until what age?_____

Does patient have any speech therapy?..... Yes No
Is the patient a mouth breather while asleep or awake?..... Yes No
Have you been informed of any missing or extra teeth?..... Yes No
Would you consider patient's diet high in carbohydrate?..... Yes No
Have full mouth x-rays attitude towards treatment?..... Yes No

What is patient's attitude towards treatment?_____
What are you or your dentist most concerned about?_____
_____

Other Comments:_____
Signed:_____ Date:_____

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CHILD & ADULT ORTHODONTICS and DENTO-FACIAL ORTHOPEDICS • Treating TMJ Disorders

3 SUMMER ST.
HANOVER, NH 03755
(603) 643-2170

188 MAIN ST.
NEW LONDON, NH 03257
(603) 526-4060

246 BROAD ST.
CLAREMONT, NH 03743
(603) 543-0066