



HENRY J. UDOUJ JR, DDS, MS
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2101 Dallas Street • Fort Smith, Arkansas 72901
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PATIENT INFORMATION

GET ACQUAINTED FORM (Please complete)

Date _____

| | | | | | | |
|---------------------------|--|-------------------------|-------------|-----|------------------|-----|
| LAST NAME | | FIRST | NICKNAME | SEX | BIRTHDATE | AGE |
| ADDRESS (Number & Street) | | CITY | STATE | ZIP | PHONE | |
| SCHOOL | | GRADE | EMPLOYED BY | | BUS. PHONE | |
| REFERRED BY | | NAME OF GENERAL DENTIST | | | S.S.# OF PATIENT | |

PARENT INFORMATION (If Patient is a minor) or Spouse information (if Patient is Adult)

| | | | | | | | |
|--------------------------------|------|---------------------------|------------|--------------------|----------------|---------------|-------|
| FATHER'S NAME OR SPOUSE'S NAME | | ADDRESS (Number & Street) | | CITY | STATE | ZIP | PHONE |
| EMPLOYED BY | SS # | DATE OF BIRTH | OCCUPATION | | BUSINESS PHONE | | |
| MOTHER'S NAME OR SPOUSE'S NAME | | ADDRESS (Number & Street) | | CITY | STATE | ZIP | PHONE |
| EMPLOYED BY | SS # | DATE OF BIRTH | OCCUPATION | | BUSINESS PHONE | | |
| Mother's Cell Phone | | Father's Cell Phone | | Patient Cell Phone | | Email address | |

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

| | | | | | | | |
|---|------------------------|---------------|---------------------|-------------------------|-------|----------------------|--|
| NAME | | SSN # | | RELATIONSHIP TO PATIENT | | | |
| ADDRESS (Number & Street) | | CITY | STATE | ZIP | PHONE | | |
| Do you have Orthodontic Insurance? | NAME OF INSURANCE PLAN | | SECONDARY INS. DOB. | | | | |
| RELATED PATIENTS WHO HAVE HAD ORTHODONTIC TREATMENT | | | | | | MEDICAID ASSISTANCE? | |
| NAME: | | RELATIONSHIP: | | TREATED BY: | | | |

MEDICAL HISTORY

DENTAL HISTORY

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------------------------|---|---------------------------------|--|---------------------------------|--|-----------------------------------|---|---|-----------------------------------|--|--|--|---|---|---------------------------------------|---------------------------------------|--|--------------------------------------|---|-----------------------------------|---|
| <p>Please check box if patient has or has had:</p> <table border="0"> <tr> <td><input type="checkbox"/> Joint swelling</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Bone disorders</td> <td><input type="checkbox"/> Anemia</td> </tr> <tr> <td><input type="checkbox"/> Heart trouble</td> <td><input type="checkbox"/> Asthma</td> </tr> <tr> <td><input type="checkbox"/> Rheumatic fever</td> <td><input type="checkbox"/> Epilepsy</td> </tr> <tr> <td><input type="checkbox"/> Thyroid problems</td> <td><input type="checkbox"/> Prolonged bleeding</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Faintness/Dizziness</td> </tr> <tr> <td><input type="checkbox"/> Hepatitis - HBV</td> <td><input type="checkbox"/> Tonsils removed</td> </tr> <tr> <td><input type="checkbox"/> Emotional problems</td> <td><input type="checkbox"/> Adenoids removed</td> </tr> <tr> <td><input type="checkbox"/> Brain injury</td> <td><input type="checkbox"/> Sore throats</td> </tr> <tr> <td><input type="checkbox"/> Kidney or liver involvement</td> <td><input type="checkbox"/> Tonsillitis</td> </tr> <tr> <td><input type="checkbox"/> AIDS, HIV-Positive</td> <td><input type="checkbox"/> Earaches</td> </tr> </table> <p>List any other serious illness:</p> <p>List any allergies:</p> <p>List drugs or medications now being taken:</p> <p>Is patient under physician's care presently? Reason:</p> <p>Name of physician:</p> <p>Approximately how much has patient grown in the last year?</p> <p>Additional comments:</p> | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Faintness/Dizziness | <input type="checkbox"/> Hepatitis - HBV | <input type="checkbox"/> Tonsils removed | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Adenoids removed | <input type="checkbox"/> Brain injury | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> AIDS, HIV-Positive | <input type="checkbox"/> Earaches | <p>Please check box if answer is yes:</p> <p><input type="checkbox"/> TMJ-Jaw clicking, locking, pain? (circle)</p> <p><input type="checkbox"/> Any injuries to face, mouth, teeth? (circle)</p> <p><input type="checkbox"/> Thumb, finger, lip sucking? (circle)</p> <p><input type="checkbox"/> Mouth-breathing when asleep, awake? (circle)</p> <p><input type="checkbox"/> More than average amount of decay?</p> <p><input type="checkbox"/> Any missing permanent teeth?</p> <p><input type="checkbox"/> Any teeth removed by extraction?</p> <p><input type="checkbox"/> Is there any tongue-thrusting problem?</p> <p><input type="checkbox"/> Any speech problems?</p> <p><input type="checkbox"/> Any difficulty in swallowing or chewing?</p> <p><input type="checkbox"/> Is patient adopted? At what age? _____</p> <p><input type="checkbox"/> Does patient visit dentist regularly? Date of last dental visit _____</p> <p><input type="checkbox"/> Has an orthodontist been consulted previously? Who? _____</p> <p>Reason: _____</p> <p>List any instrument played:</p> <p>Sports or Hobbies:</p> <p>What would you like to have orthodontic treatment accomplish?</p> <p>Patients attitude toward having orthodontics: (circle one) Wants It Done Does Not Want It Done Does Not Care</p> |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Tuberculosis | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Anemia | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Asthma | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Epilepsy | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Prolonged bleeding | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Faintness/Dizziness | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Hepatitis - HBV | <input type="checkbox"/> Tonsils removed | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Adenoids removed | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Sore throats | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Kidney or liver involvement | <input type="checkbox"/> Tonsillitis | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> AIDS, HIV-Positive | <input type="checkbox"/> Earaches | | | | | | | | | | | | | | | | | | | | | | |

I understand that where appropriate, credit bureau reports may be obtained.

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