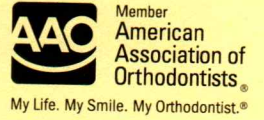


HENRY J. UDOUJ III, DDS, MS

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2101 Dallas Street • Fort Smith, Arkansas 72901

Branch Office
808 South Broadway • Poteau, Oklahoma 74953
www.udoujorthodontics.com



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 <input type="checkbox"/> Self <input type="checkbox"/> Family Dentist <input type="checkbox"/> Friend _____ <input type="checkbox"/> Website <input type="checkbox"/> TV/Billboard <input type="checkbox"/> 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
 Work #: _____
 Marital Status: _____
 e-mail: _____
 Employer: _____
 Position: _____

Please complete the following if applicable:

Spouse Name: _____
 DOB: _____
 Relationship to Patient: _____
 Phone: _____ TYPE: cell / home / work
 SSN: _____
 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: _____

MEDICAL HISTORY QUESTIONNAIRE

Please check all that apply to patient.

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