Acquaintance Card

McGRORY ORTHODONTICS
shaping smiles · shaping lives

Date _____

Patients' Full Name _____ Nickname _____

__ Male __ Female Age _____ Date of Birth _____ Phone # _____

Contact email _____

Patient's Dentist _____ Date of last visit: _____

If patient is an adult, please fill out this section:

Home Address _____

Employed by _____ Bus. Address _____ Phone _____

Spouse's Full Name _____ Employed by _____ Phone _____

If patient is a student, please fill out this section:

School _____ Grade _____

Father's Name _____ Mother's Name_____

Home Address _____

Father Employed by _____ Bus. Address _____ Phone _____

Mother Employed by _____ Bus. Address _____ Phone _____

All patients' please fill out the remainder of the form:

Person Responsible for Account _____ SS# _____

Address _____

Patient's Physician _____

Is there any orthodontic insurance we can check for you? ..... ☐ Yes ☐ No

If so, list Insurance Company _____ Phone _____

Policy Holder _____ DOB _____ SSN# _____ Employer _____

Relatives treated at this office _____

Have you been under the care of a physician during the past two years? ..... ☐ Yes ☐ No

(If so, state condition and duration) _____

Please check any of the following for which you have been treated:

☐ Diabetes	☐ Anemia	☐ Epilepsy	☐ Fainting or Dizziness
☐ Pneumonia	☐ Asthma	☐ Nervous Disorder	☐ Hepatitis or Jaundice
☐ Heart Trouble	☐ Rheumatic Fever	☐ Kidney Trouble	☐ HIV
☐ Bone DIsorders	☐ Tuberculosis	☐ Endocrine Problem	☐ Prolonged Bleeding

List any medications now being taken _____

List any allergies or drug sensitivity _____

Have your tonsils or adenoids been removed? (At what age? _____) ..... ☐ Yes ☐ No

Have you ever sucked your thumb or finger? (Until what age? _____) ..... ☐ Yes ☐ No

Do you have any speech problems? ..... ☐ Yes ☐ No

Are you a mouth breather? ..... ☐ Yes ☐ No

Do you play a musical wind instrument? ..... ☐ Yes ☐ No

Has another orthodontist been consulted previously? ..... ☐ Yes ☐ No

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Whom may we thank for referring you to our office? _____

Signature of Patient, Parent, or Guardian _____ Date _____