

CONFIDENTIAL

Member
American Association of
Orthodontists

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GET ACQUAINTED QUESTIONNAIRE
FOR PATIENT'S UNDER 18 YEARS OF AGE

The following information is needed to enable us to give you the most consideration and best service possible. This information is, of course, confidential. Thank you.

Patient's full name _____ Nickname _____

Sex _____ Age _____ Birthday _____ Height _____ ' _____ " Weight _____

School _____ Grade _____ Scholastic performance _____

Like or dislike school? _____ Musical Instrument Played _____

Favorite Sports, Hobbies, & Avocations _____

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

IN CASE WE CANNOT REACH YOU:

Person to contact _____ Phone No. _____

ORTHODONTIC INSURANCE COVERAGE: yes no

Primary Insurance Co. _____ Policy No. _____

Policy Holder Name _____ SSN# _____ D.O.B. _____

Secondary Insurance Co. _____ Policy No. _____

Policy Holder Name _____ SSN# _____ D.O.B. _____

FAMILY INFORMATION

Patient's Address _____ City _____ Zip _____ Phone# _____

How long? _____ Anticipate Moving? _____ When and Where _____

Father's Name _____ Height _____ Address _____ Phone no. _____

Father's Occupation _____ Employer _____ Bus. Phone _____

Mother's Name _____ Height _____ Address _____ Phone no. _____

Mother's Occupation _____ Employer _____ Bus. Phone _____

How many brothers _____ Ages _____ Sisters _____ Ages _____

Do they have any orthodontic problems? _____

Have they had any orthodontic treatment? _____ Natural parents: yes no

Does father have normal teeth? _____ Father treated? _____

Does mother have normal teeth? _____ Mother treated? _____

Who is legally responsible for the patient? _____ SS# _____ phone no. _____

Date _____ **Signed** _____

We want to thank you for your cooperation in supplying the above information.

PATIENT INFORMATION