Dr. Roland G. Nentwich D.D.S., M.S., P.C.
506 Main Street, Shrewsbury, MA 01545 ● 508.845.6711 ● Fax: 508.842.0648
1084 Main Street, Holden MA, 01520 ● 508.829.4309

OFFICE USE

DATE_____________

REC#_____________

ACQUAINTANCE FORM & HEALTH HISTORY

Patient's Name_________________________________ Nickname_________________________________

Home Address_____________________________ City____________________ Zip Code_____________

Date of Birth______________________ E-mail ____

Home Phone _________________ Cell Phone _______________ Emergency Contact_________________

Family Dentist____ Phone_____________________________

Family Physician______________________________________ Phone_____________________________

School/Employer_______________________________________ Phone_____________________________

Family Members Seen? ____ Full Braces? _________________

Name & Ages of Siblings (Recommended age for first orthodontic visit is age 7)

____

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

What concerns do you have?____

PERSON RESPONSIBLE FOR ACCOUNT: (if patient is a minor)

- Mother__________________________________ E-mail__________________________________

Address ___________________________________ City________________________ Zip______________

Home #_____________________________________ Cell #_____________________________________

Employer___________________________________ Work # ___________________________________

- Father_____________________________________ E-mail________________________________

Address ___________________________________ City________________________ Zip______________

Home #_____________________________________ Cell #_____________________________________

Employer___________________________________ Work # ___________________________________

- Emergency Information (who should we contact in case of an emergency)

Name____________________ Relationship to patient_____________________ Phone_________________

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DENTAL INSURANCE

Name of Policy Holder____ Birthdate_____________

ID#_____________________ Group#______________________ Expected Benefit $_______________

Delta of ______________ BC/BS of______________ Altus ________________ Other_______________

SECONDARY DENTAL INSURANCE

Name of Policy Holder____Birthdate_____________

ID#_____________________ Group#______________________ Expected Benefit $_______________

Delta of ______________ BC/BS of______________ Altus ________________ Other_______________

Please underline any of the following that apply and describe below as needed:

Allergies	Eye aches	Hormonal problems	Rheumatic fever	Anemia/blood disorder
Fainting	Mononucleosis	Sinusitis	Mouth Breathing	Reactions to medications
Asthma	Convulsions	Heart Problems	Nervous disorder	Speech Problem
Diabetes	Heart Murmur	Herpes	Poor appetite	Sore Throats (frequent)
Earaches	Hepatitis	Prolonged bleeding	Epilepsy	Vomiting/ eating disorder
Thyroid	Headaches			

Describe:
____
____
____
____
____
____

Any previous orthodontic care? ---Yes No

If so what treatment? ____

- Please have previous orthodontic records sent to OfficeInfo@orthodonticsolution.com before your consultation appoinment.

Presently under a physician's care? -- Yes No

List any medications currently being taken: (include birth control)
____
____
____
____

List any hospitalizations since birth: ____
____
____

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Has there been any clicking or snapping of the joint in front of the ears? ---------------------------- Yes No

- If so please circle, Right Joint Left Joint Both

Any grinding or clenching of teeth? --Yes No

Any injuries to the face or jaw?---Yes No
(Explain)____
____
____

Are the tonsils and adenoids still present? -- Yes No

(any problems with tonsils/adenoids?)-- Yes No

Any thumb/finger habits past or present? -- Yes No

Are frequent cold sores or canker sores a problem? -- Yes No

Are you currently, or any chance you may be pregnant (Female)---Yes No

IF PATIENT IS A CHILD:

Do you feel his/her physical development is behind average for age? -- Yes No

Is his/her progress in school: average_____________ below average_____________ above average____________

Has pubertal growth taken place? ---Yes No

Age menstruation started (if female)? ____________

Please relate any other information you believe may be important .

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