



# 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 \_\_\_\_\_

Record # \_\_\_\_\_

## ACQUAINTANCE FORM & HEALTH HISTORY

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of person referring you to this office: \_\_\_\_\_

Family members seen at this office: Who? Were they in full braces? \_\_\_\_\_

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

Father \_\_\_\_\_ Mother \_\_\_\_\_

Address if different than patient \_\_\_\_\_ Mother \_\_\_\_ Father \_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_

Occupation of Father \_\_\_\_\_ Business Phone: \_\_\_\_\_ May we call? \_\_\_\_\_

Occupation of Mother \_\_\_\_\_ Business Phone: \_\_\_\_\_ May we call? \_\_\_\_\_

### ORTHODONTIC INSURANCE CO. (Please complete fully)

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_

ID# \_\_\_\_\_ Delta \_\_\_\_ BC/BS \_\_\_\_

Other \_\_\_\_\_

Expected Benefit \_\_\_\_\_

Second Insurance \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_

ID# \_\_\_\_\_ Delta \_\_\_\_ BC/BS \_\_\_\_

Other \_\_\_\_\_

Expected Benefit \_\_\_\_\_



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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                  |
| Asthma                  | Headaches      | Mouth breathing          | Speech problem             |
| Convulsions             | Heart problems | Nervous disorder         | Sore throats (frequent)    |
| Diabetes                | Heart murmur   | Poor appetite            | Thyroid                    |
| Earaches                | Hepatitis      | Prolonged bleeding       | Vomiting / eating disorder |
| Epilepsy                | Herpes         | Reactions to medications |                            |

Describe: \_\_\_\_\_

\_\_\_\_\_

Has the patient had any previous orthodontic care? ..... Yes No

If so, what treatment? \_\_\_\_\_

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

List any medications currently being taken (including birth control medication):  
\_\_\_\_\_  
\_\_\_\_\_

List any hospitalization since birth:  
\_\_\_\_\_  
\_\_\_\_\_

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

Any grinding or clenching of teeth? ..... Yes No

Any injuries to the face or jaw? \_\_\_\_\_

*Please explain*

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

Have they presented any problems? ..... Yes No

Any Thumb/Finger habits past or present? ..... Yes No

Are frequent cold sores or canker sores a problem? ..... 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

Have pubertal growth changes taken place? ..... Yes No

Age menstruation started (if female)? \_\_\_\_\_

Please relate any other information you believe may be important: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_