

PATIENT REGISTRATION

NAME _____ NICKNAME _____ SEX _____ AGE _____ DATE _____
ADDRESS _____ CITY/STATE _____ ZIP _____
SSN _____ BIRTHDATE _____ HOME PHONE _____ CELL _____
SCHOOL _____ GRADE _____
INTERESTS OR HOBBIES _____
SIBLINGS NAMES AND AGE _____
PATIENT'S DENTIST _____ DATE OF LAST VISIT _____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
DO YOU KNOW ANY PATIENTS IN OUR PRACTICE? IF SO, WHO? _____
PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:
 SUGGESTED BY DENTIST CROWDING SPACING BAD BITE OVERBITE
 UNDER BITE EXCESSIVE WEAR/GRINDING HABITS GUMMY SMILE
 OTHER _____

RESPONSIBLE PARTY INFORMATION

NAME _____ MARITAL STATUS _____
ADDRESS _____ CITY/STATE _____ ZIP _____
HOW LONG AT THIS ADDRESS _____ WORK PHONE _____ HOME _____ CELL _____
SSN _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____
SPOUSE'S NAME _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
SSN _____ WORK PHONE _____ HOME _____ CELL _____
EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SSN _____
INSURANCE CO _____ GROUP# _____ INSURANCE PHONE _____
INSURED ADDRESS _____
PATIENT'S RELATIONSHIP TO INSURED _____
EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____
INSURANCE CO ADDRESS _____ EFFECTIVE DATE _____
DO YOU HAVE DUAL COVERAGE? YES NO **IF YES: PLEASE COMPLETE BELOW**
INSURED'S NAME _____ INSURED'S SSN _____
INSURANCE CO _____ GROUP# _____ INSURANCE PHONE _____
INSURED ADDRESS _____
PATIENT'S RELATIONSHIP TO INSURED _____
EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____
INSURANCE CO ADDRESS _____ EFFECTIVE DATE _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ CITY _____ LAST SEEN _____

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | IS PATIENT EXPERIENCING ANY HEALTH PROBLEMS? PLEASE EXPLAIN _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | DOES PATIENT HAVE HISTORY OF MAJOR ILLNESS? PLEASE EXPLAIN _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HAS PATIENT EVER BEEN ADMITTED FOR HOSPITAL? FOR WHAT REASON _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | IS PATIENT TAKING ANY MEDICATIONS OR DRUGS? PLEASE LIST _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | IS PATIENT ALLERGIC TO ANY MEDICATIONS OR DRUGS? PLEASE LIST _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HAS PATIENT'S TONSILS OR ADENOIDS BEEN REMOVED? WHAT AGE? _____ |

PLEASE CIRCLE ANY OF THESE FOLLOWING IF PATIENT HAS BEEN DIAGNOSED WITH:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> ADD, ADHD | <input type="checkbox"/> DEVELOPMENTAL DISORDER | <input type="checkbox"/> GROWTH DISORDERS | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEAD OR NECK PAIN | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> MITRAL VALVE PROLAPSE |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PROLONGED BLEEDING |
| <input type="checkbox"/> BONE DISORDER | <input type="checkbox"/> EMOTIONAL DISORDER | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FAINTING | <input type="checkbox"/> HIV OR AIDS | <input type="checkbox"/> TUBERCULOSIS |

OTHER CONDITIONS NOT MENTIONED _____

NEAREST RELATIVE IN CASE OF EMERGENCY _____ PHONE _____ RELATIONSHIP _____

DENTAL HISTORY

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | STARTED TEETHING VERY EARLY OR LATE? |
| <input type="checkbox"/> | <input type="checkbox"/> | PRIMARY (BABY) TEETH REMOVED THAT WERE NOT LOOSE? |
| <input type="checkbox"/> | <input type="checkbox"/> | HAS PATIENT HAD ANY UNPLEASANT EXPERIENCE IN A DENTAL OFFICE? |
| <input type="checkbox"/> | <input type="checkbox"/> | PREVIOUS INJURIES TO FACE, MOUTH, OR TEETH? |
| <input type="checkbox"/> | <input type="checkbox"/> | THUMB OR FINGER SUCKING HABIT? IF SO, UNTIL WHAT AGE? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HISTORY OF SPEECH PROBLEMS? |
| <input type="checkbox"/> | <input type="checkbox"/> | ABNORMAL SWALLOWING HABIT OR TONGUE THRUSTING? |
| <input type="checkbox"/> | <input type="checkbox"/> | MOUTH BREATHING HABIT OR DIFFICULTY BREATHING? |
| <input type="checkbox"/> | <input type="checkbox"/> | MISSING OR EXTRA PERMANENT TEETH? |
| <input type="checkbox"/> | <input type="checkbox"/> | PERIODONATAL (GUM) PROBLEMS OR BONE LOSS? |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY TEETH IRRITATING CHEEK, LIP, OR TONGUE |
| <input type="checkbox"/> | <input type="checkbox"/> | CLICKING OR POPPING OF THE JAW? |
| <input type="checkbox"/> | <input type="checkbox"/> | DIFFICULTY IN OPENING, CLOSING, OR CHEWING? |
| <input type="checkbox"/> | <input type="checkbox"/> | PAIN OR SORENESS IN MUSCLES OF FACE OR AROUND THE EARS? |
| <input type="checkbox"/> | <input type="checkbox"/> | CLENCHING OR GRINDING OF THE TEETH WHILE AWAKE OR ASLEEP? |
| <input type="checkbox"/> | <input type="checkbox"/> | IS PATENT CONCERNED ABOUT APPEARANCE OF TEETH? |
| <input type="checkbox"/> | <input type="checkbox"/> | WOULD YOU MIND WEARING BRACES IF NEEDED? |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE YOU HAD ANY PREVIOUS ORTHODONTIC TREATMENT? |
| <input type="checkbox"/> | <input type="checkbox"/> | HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?
WHO? _____ WHERE ? _____ DATE _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | HAVE ANY FAMILY MEMBERS HAD ORTHODONTIC TREATMENT? WHO? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | ANY OTHER INFORMATION THAT MAY BE HELPFUL _____ |

I understand that where appropriate, credit bureau reports may be obtained. If there are any changes to this history record of medical/dental status, I will so inform this practice.

Parent/Guardian Signature _____ Date _____