PATIENT REGISTRATION

Patient's Name _____ Parent's Name _____

Prefers to be called _____ Parent's Address(If different from patient)

Age_____Birthdate_____Sex____ Street or Route _____

City & State _____

Zip Code _____

Email _____

Address:

Street or Route _____

City & State _____ Parent's Employer _____

Zip Code _____ Parent's Employer Phone _____

Do both parents live at the same address? Yes____ No____

Phone Number _____ Patient's Dentist _____

Parent's Cell Phone _____ Date of Last Visit _____

Phone # for reminder calls_____

School _____Grade_____ Patient's Physician _____

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

What is/are your concerns regarding your child's teeth/bite? _____

Has any family member been treated by our office? _____

Name of Family member treated _____Relationship_____

Has the patient had any of the following: Circle Yes or No

1. Rheumatic Fever.....Yes No
2. Heart Condition.....Yes No
3. Diabetes.....Yes No
4. Epilepsy.....Yes No
5. Hemophilia (Bleeding Disorder).....Yes No
6. Allergies.... Allergic to what? _____.....Yes No
7. Drug Reaction....Which drug?_____.....Yes No
8. Hepatitis.....Yes No
9. Venereal Disease.....Yes No
10. Aids or Related HIV.....Yes No
11. Tuberculosis.....Yes No
12. Family Member with Tuberculosis?.....Yes No
13. Latex Allergy?.....Yes No
14. Is patient under care of a physician at present?.....Yes No
15. Is patient now or has ever been under the care of a psychiatrist?.....Yes No

Is there any health condition not listed above?

Please describe _____

Is your child taking any prescription or over-the-counter drugs?.....Yes No

Please list each one _____

1. Does patient breathe with their mouth open most of the time?.....Yes No
2. Have tonsils and adenoids been removed?.....Yes No
3. Does patient suck their thumb?.....Yes No
4. Has patient ever injured teeth in fall or accident?.....Yes No

Was dental treatment required?.....Yes No

Please comment and give approximate date of injury_____

5. Does any relative of the patient have a similar orthodontic problem?.....Yes No

Relationship_____

Continued on the Back

Who is responsible for the financial aspect of your child's orthodontic treatment?

Father____ Mother____ Other_____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number
Insurance Company Address		
Insurance Phone Number		
Insured's Employer		

Do you have secondary **Orthodontic** coverage?		Yes O No O
Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number
Insurance Company Address		
Insurance Company Phone Number		
Insured's Employer		

Once you complete this form our staff will escort your child to the examination room.

After the doctor completes the examination we will escort your child to a private conference room where the doctor will discuss the orthodontic treatment with you.

Thank you for choosing our office for your child's orthodontic care!

Parent/Guardian Signature_____**Date**_____