PATIENT REGISTRATION

Patient's Name _____

Prefers to be called _____

Age_____Birthdate_____Sex____

Address:
Street or Route _____
City & State _____
Zip Code _____

Parent's Name _____

Parent's Address(if different from patient)
Street or Route _____
City & State _____
Zip Code _____
Email _____
(for appointment reminders)
Responsible Party Employer _____
Responsible Party Employer Phone _____

Do both parents live at the same address? Yes____ No____

Phone Number _____
Parent's Cell Phone _____
Phone # for reminder calls_____

School _____Grade_____

Patient's Dentist _____
Date of Last Visit _____

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 Q No Q
Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number
Insurance Company Address		
Insurance Company Phone Number		
Insured's Employer		

Parent/Guardian Signature_____**Date**_____

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