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PATIENT REGISTRATION

Date ______________________________
Patient # __________________________

Patient's Name____ Sex M F Age____________
LAST FIRST MIDDLE

Address____ Phone ___________________
CITY STATE ZIP

Favorite Name (if different)______________________ Birthdate____________________ Grade____________ School ______________________
mo/day/yr

Father's Name____ Cell # ___________________

Address____ Phone ___________________
CITY STATE ZIP

Mother's Name____ Cell # ___________________

Address____ Phone ___________________
CITY STATE ZIP

Email Address (required for correspondence/reminders) ______________________________________

Person(s) with patient at exam______________________________ Relationship to patient______________________

Main concern______________________________ Who may we thank for referring you?______________________

Has patient seen another orthodontist (circle) YES NO If yes, name______________________________

Has any immediate family member been to our office before regarding orthodontics? (circle) YES NO If yes, who? ____________________

Family dentist______________________ City____________________ Date of last dental check-up ______________

Person(s) responsible for this account____ Phone______________________

Father's occupation______________________ Employer______________________ Business Phone______________________

Mother's occupation______________________ Employer______________________ Business Phone______________________

Dental insurance (circle) YES NO If yes, company______________________ ID #______________________

Medical insurance (circle) YES NO If yes, company____

FOR INSURANCE PURPOSES: Mother's Date of Birth______________________ Father's Date of Birth______________________
mo/day/yr mo/day/yr

Mother's Social Security #______________________ Father's Social Security #______________________

MEDICAL/DENTAL HISTORY

Family Physician______________________ Date of last physical____________________ General health ____________________

Is patient under a physician's care? YES ❑ NO ❑ If so, for what? ______________________________

List any medications now being taken:______________________ For what reason? ______________________

List any allergies, drug or latex sensitivity: ____

Have tonsils and adenoids been removed? YES ❑ NO ❑ Is patient a mouth-breather? YES ❑ NO ❑

Does patient vomit, gag, or faint easily? YES ❑ NO ❑ Explain ______________________________

Has patient been diagnosed or treated for any of the following, indicate by circling appropriately:

Rheumatic Fever	YES	NO	Blood Disorders	YES	NO	Lung Disorders	YES	NO	Bone Disorders	YES	NO
Heart Disease	YES	NO	Anemia	YES	NO	Asthma	YES	NO	Arthritis	YES	NO
Abnormal Blood Pressure	YES	NO	Hepatitis	YES	NO	Diabetes	YES	NO	Other	YES	NO
Heart Murmur	YES	NO	AIDS/HIV Pos.	YES	NO	Seizures	YES	NO	Explain		

Does Patient require Antibiotic Pre-Medications? YES NO Explain: ______________________________

Does the patient experience headaches or neckaches, especially under stress?	YES	SOMETIMES	NO
Does the patient grind or clench teeth?	YES	SOMETIMES	NO
Has the patient had any jaw or head injuries?	YES		NO
Does the patient experience any clicking, popping or pain while chewing or yawning?	YES	SOMETIMES	NO
Has the patiend experienced any episodes of jaws locking in the open or closed positions?	YES	SOMETIMES	NO
Has the patient ever consulted anyone regarding a jaw problem?	YES		NO
Have any teeth been injured due to an accident or fall?	YES		NO
Does the patient have a persistent thumb or finger habit?	YES		NO
Is there any reason the patient may have problems with orthodontic treatment?	YES		NO
Is the patient/parent aware that appointments will infringe on school/work time?	YES		

PARENT/GUARDIAN SIGNATURE______________________________ **DATE**____________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________