—Orthodontics for Children and Adults—
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Comprehensive Patient Registration Record

All Information Listed is
STRICTLY CONFIDENTIAL

PATIENT INFORMATION—CHILD

Patient's Name: ____________________ Preferred Name: ____________

Birth date: ____________ Age: ____________ Sex: ☐ M ☐ F

Address: ____________ City/State/Zip: ____________

Home Phone: ____________ Family Email: ____________

School: ____________ Grade Level: ____________

Parent's Marital Status: ____________ Who is patient living with? ____________

Cell phone# of parent most likely to accompany patient to appointments: ____________

Are there other family members that come to our office? ____________

Patient's Dentist: ____________ Who can we thank for referring you? ____________

RESPONSIBLE PARTY INFORMATION

MOTHER: ____________ Social Security #: ____________ Birth date: ____________

Address: ____________ City/State/Zip: ____________

Home Phone: ____________ Cell Phone: ____________ Business Phone: ____________

Employer: ____________ Occupation: ____________

FATHER: ____________ Social Security #: ____________ Birth date: ____________

Address: ____________ City/State/Zip: ____________

Home Phone: ____________ Cell Phone: ____________ Business Phone: ____________

Employer: ____________ Occupation: ____________

DENTAL INSURANCE INFORMATION

PRIMARY Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name ____________

Relationship to Patient: ____________

Insured's SS# ____________

Insured's Birth date: ____________

Insured's Employer: ____________

Insurance Co. Name: ____________

Subscriber ID#: ____________

Insurance Co. Group #: ____________

Insurance Co. Address: ____________

____

Insurance Co. Phone #: ____________

SECONDARY Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name ____________

Relationship to Patient: ____________

Insured's SS# ____________

Insured's Birth date: ____________

Insured's Employer: ____________

Insurance Co. Name: ____________

Subscriber ID#: ____________

Insurance Co. Group #: ____________

Insurance Co. Address: ____________

____

Insurance Co. Phone #: ____________

CHILD MEDICAL HISTORY

Please indicate whether or not your child has ever had any of the following medical conditions by circling (y)es (n)o.

Y	N	ADD/ADHD	Y	N	Emotional Problems	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Epilepsy/Seizures	Y	N	Oral Ulcer
Y	N	Arthritis	Y	N	Headache/Migraine	Y	N	Previous Surgery
Y	N	Artificial Joints/Valves	Y	N	Heart Condition/Murmur	Y	N	Rheumatic Fever
Y	N	Asthma/Difficulty Breathing	Y	N	Hemophilia/ Abnormal	Y	N	Thyroid Problems
Y	N	Birth/Congenital Defects	Y	N	Bleeding	Y	N	Tuberculosis
Y	N	Cancer	Y	N	Hepatitis	Y	N	Tonsils removed–Age:
Y	N	Cold Sores	Y	N	Herpes	Y	N	Adenoids Removed–Age:
Y	N	Diabetes	Y	N	HIV positive	Y	N	Mouthbreather
Y	N	Endocrine Problems	Y	N	Kidney/Liver Problems			

ALLERGIES: Medications— Y or N If yes, please list. ______

Latex— Y or N Metals— Y or N Plastic/Acrylic— Y or N

Other— Y or N If yes, please list. ______

Is patient currently being seen for any injury or illness? Y or N If yes, please explain: ______

Are there any other medical concerns we should be aware of? Y or N If yes, please explain: ______

Does patient need to be pre-medicated prior to dental visits? Y or N If yes, do you have prescription filled? Y or N

Has the patient reached puberty? Girls—Has she started menstruation? Y or N—If yes, approximately when? ______

Boys—Has his voice changed? Y or N—If yes, approximately when? ______

Is patient adopted? Y or N If yes, please explain: ______

Name of Physician: ______ Phone: ______

Please list any medication(s) patient is currently taking, along with reason for the medication(s):

______ ______

______ ______

CHILD DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

When did the patient last visit the dentist? ______

Why is the patient seeking an orthodontic consultation? ______

Has the patient had a prior orthodontic consultation or treatment? Y or N—If yes, Date: ______ Dr: ______

Does the patient have any speech problems? Y or N—If yes, is patient currently in speech therapy? Y or N

Has the patient ever had a severe head, neck or facial injury? Y or N—If yes, please explain: ______

Does the patient:

- Difficulty in mouth opening? Y or N—If yes, please explain: ______
- Pain or clicking in the jaw joint? Y or N—If yes, please explain: ______
- Pain on chewing, yawning, or wide opening? Y or N—If yes, please explain: ______
- Pain in or about the ears or cheeks? Y or N—If yes, please explain: ______
- A bite that feels "uncomfortable" or "unusual"? Y or N—If yes, please explain: ______
- A jaw that "locks", "gets stuck", or "goes out"? Y or N—If yes, please explain: ______
- Noises in or from the jaw joints? Y or N—If yes, please explain: ______

The following habits are of interest. List information as it pertains to this patient:

- Thumb/finger/lip sucking until ______ age Y or N—If yes, please explain: ______
- Grinding or clenching of teeth? Y or N—if yes, please explain: ______
- Tongue thrusting or other functional problem? Y or N—If yes, please explain: ______

Have you been informed of any missing or extra permanent teeth? Y or N—If yes, please explain: ______

I authorize X-rays and Diagnostic Photos to be taken for diagnostic purposes to be able to give you the most accurate information possible at the Initial Examination appointment.

I have read an understand the above questions. I will not hold my orthodontist or any member of his team responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to contact this office with any changes in my child's medical/dental status.

Signature of Parent/Guardian: ______ Today's Date: ______