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PATIENT REGISTRATION
HISTORY - CHILD

PATIENT NAME _____ DATE ____/____/____

BIRTH DATE ____/____/____ ☐ MALE ☐ FEMALE GRADE _____ HOBBIES _____

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ E-MAIL _____ CELL/PAGER _____

MOTHER'S NAME _____ FATHER'S NAME _____

MOTHER'S EMPLOYER _____ FATHER'S EMPLOYER _____

OCCUPATION _____ SOCIAL SEC#_____ OCCUPATION _____ SOCIAL SEC# _____

SIBLINGS _____ PATIENT LIVES WITH ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER

BILLING NAME _____ RELATIONSHIP TO PATIENT _____

BILLING ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

ADDRESS _____ MEDICAL ID# _____
(STREET) (CITY) (STATE) (ZIP)

YES	NO	
☐	☐	Has patient undergone a physical exam in the past year?
☐	☐	Is patient presently under a physician's care?
☐	☐	Has patient ever had a major surgery?
☐	☐	Has patient ever been hospitalized?
☐	☐	Is patient taking any pills, medications or drugs?
☐	☐	Is patient allergic to novocaine or penicillin?
☐	☐	Has patient had any unusual reaction to any medication?
☐	☐	has patient had tonsils and/or adenoids removed?
☐	☐	Does patient have fainting or dizzy spells?
☐	☐	Does patient have a too high or low blood pressure?

Has patient ever been diagnosed or treated for the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Kidney Problems	☐	☐	Hepatitis
☐	☐	Rheumatic Fever	☐	☐	Lung Problems	☐	☐	Emotional Problems
☐	☐	Liver Problems	☐	☐	Malignancies	☐	☐	Allergies
☐	☐	Endocrine Problems	☐	☐	Diabetes	☐	☐	Bone Problems
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding	☐	☐	Anemia
☐	☐	Tuberculosis	☐	☐	Arthritis	☐	☐	Asthma

Are there any other medical problems I should be aware of? _____

IF YES, PLEASE EXPLAIN _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

DATE OF LAST CLEANING _____ ANY PENDING WORK? _____

WHAT IS THE MAJOR CONCERN ABOUT THE PATIENT'S TEETH? _____

YES	NO	
☐	☐	Has the patient ever had previous orthodontic consultation or treatment?
☐	☐	Has patient been informed of any extra or missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Has any family member had orthodontic treatment?
		Who? _____
☐	☐	Does patient now suck his/her thumb or finger?
☐	☐	Does patient breath predominantly through the mouth?
☐	☐	Does patient have any speech problems?

YES	NO	
☐	☐	Does patient grind or clench his/her teeth?
☐	☐	Does patient have pain or clicking of the jaw joint?
☐	☐	Have any teeth been injured or chipped due to an accident?
☐	☐	Has patient ever had pains in the face or head?
☐	☐	Has patient ever had severe jaw or head injury?
☐	☐	Do patient's gums bleed on brushing or flossing?
☐	☐	Is patient concerned about the appearance of his/her teeth?
☐	☐	Does patient want his/her teeth straightened?

Are there any other dental/orthodontic problems I should be aware of? _____

I UNDERSTAND THAT WHEN APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

Parent/Guardian Signature _____ Date _____