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PATIENT REGISTRATION HISTORY - CHILD

Thank you for completing the information below. Your information in this history form will help us provide the best care and service for you.

Whom may we thank for referring you? _____

PATIENT NAME _____ DATE ____/____/____

AGE _____ SEX: ☐ MALE ☐ FEMALE BIRTH DATE ____/____/____ GRADE _____ SCHOOL _____

HOME ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ PATIENT LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ OTHER

MOTHER'S NAME _____ DOB _____ FATHER'S NAME _____ DOB _____

BILLING NAME _____ RELATIONSHIP TO PATIENT _____

BILLING ADDRESS _____
STREET CITY STATE ZIP

SIBLINGS _____

MOTHER'S EMPLOYER _____ OCCUPATION _____

FATHER'S EMPLOYER _____ OCCUPATION _____

MEDICAL HISTORY

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

ADDRESS _____ MEDICAL ID# _____
STREET CITY STATE ZIP

YES	NO		YES	NO		YES	NO	
		Has patient been diagnosed or treated for the following?						
☐	☐	Has patient undergone a physical exam in the past year?	☐	☐	Heart Problems	☐	☐	Hepatitis
☐	☐	Is patient presently under a physician's care?	☐	☐	Kidney Problems	☐	☐	Rheumatic Fever
☐	☐	Has patient ever had a major surgery?	☐	☐	Lung Problems	☐	☐	Emotional Problems
☐	☐	Has patient ever been hospitalized?	☐	☐	Liver Problems	☐	☐	Malignancies
☐	☐	Is patient taking any pills, medications or drugs?	☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Is patient allergic to novocaine or penicillin?	☐	☐	Diabetes	☐	☐	Bone
☐	☐	Has patient had any unusual reaction to any medication?	☐	☐	Epilepsy	☐	☐	Prolonged Bleeding
☐	☐	Has patient had tonsils and/or adenoids removed?	☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Does patient have fainting or dizzy spells?	☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Does patient have a too high or low blood pressure?						

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

DENTAL HISTORY

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

ADDRESS _____
STREET CITY STATE ZIP

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

YES	NO		YES	NO	
☐	☐	Has the patient had previous orthodontic consultation or treatment?	☐	☐	Does patient grind or clench his/her teeth?
☐	☐	Has patient been informed of any extra or missing teeth?	☐	☐	Does patient have pain or clicking of the jaw joint?
☐	☐	Have any permanent teeth been removed by extraction?	☐	☐	Have any teeth been injured or chipped due to an accident?
☐	☐	Has any family member had orthodontic treatment?	☐	☐	Has patient ever have pains in the face or head?
		Who? _____	☐	☐	Has patient ever had severe jaw or head injury?
☐	☐	Does patient now suck his/her thumb or finger?	☐	☐	Do patient's gums bleed on brushing or flossing?
☐	☐	Does patient breath predominantly through the mouth?	☐	☐	Is patient concerned about the appearance of his/her teeth?
☐	☐	Does patient have any speech problems?	☐	☐	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 _____