



New Patient Registration

For Our Patients 18 and under

Patient Information

Last Name _____ First Name _____ Middle Initial _____ Preferred Name _____
Date of Birth _____ Age _____ Gender: M F Social Security Number _____
Home Address _____ City _____ State _____ Zip _____
Cell Phone _____ Family Dentist _____ Family Physician _____
Current School _____ Grade _____ Emergency Contact Person _____
Siblings:
Name _____ Birthdate _____ Name _____ Birthdate _____
Name _____ Birthdate _____ Name _____ Birthdate _____

Who/Whom may we thank for referring you to our office? _____

Family Information

Father's Name _____ Date of Birth _____ Social Security Number _____
Father's Address (if different from child's) _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Cell Carrier _____
Employer _____ Email _____

Mother's Name _____ Date of Birth _____ Social Security Number _____
Mother's Address (if different from child's) _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Cell Carrier _____
Employer _____ Email _____

Responsible Party Information

Who is the person responsible for the child's account? Father Mother Other (please see below if other)
Other's Name _____ Date of Birth _____ Social Security Number _____
Other's Address (if different from child's) _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Cell Carrier _____
Employer _____ Relationship to Child _____

Orthodontic/Dental Insurance Information

Primary Dental Insurance: Does the child have primary orthodontic coverage? Yes No
Insured's Name _____ Relationship to Child _____
Social Security Number _____ Date of Birth _____ Employer _____
Dental Insurance Carrier _____ Group/ID Number _____

Secondary Dental Insurance: Does the child have secondary orthodontic coverage? Yes No
Insured's Name _____ Relationship to Child _____
Social Security Number _____ Date of Birth _____ Employer _____
Dental Insurance Carrier _____ Group/ID Number _____

Health Questionnaire

Medical History

- Yes No Is the patient in good health? If no, please explain_____
- Yes No Is the patient currently being treated by a physician? If yes, please explain_____
- Yes No Any previous hospitalization or serious illness? If yes, please explain_____
- Yes No Is the patient allergic to latex?
- Yes No Is the patient allergic to any medications? If yes, please list:_____
- Yes No Is the patient taking any medications? If yes, please list:_____

Does the patient now, or have they ever had a history of any of the following (Mark Y for Yes or N for No):

- | | | |
|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Lung Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Easy Bruising | <input type="checkbox"/> Y <input type="checkbox"/> N Nose Bleeds | <input type="checkbox"/> Y <input type="checkbox"/> N Eye Problems/Glaucoma |
| <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect |
| <input type="checkbox"/> Y <input type="checkbox"/> N Yellow Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness or Fainting |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ear Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Condition | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis type ____ | <input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Swallowing Problems | <input type="checkbox"/> Y <input type="checkbox"/> N HIV Positive |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bisphosphonate Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tumor/Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Bone Disorders |

Females Only:

- Yes No Is it possible that the patient may be pregnant?
- Yes No Has menstruation begun? If yes, when did it begin?_____

Yes No Are there any medical conditions we have not discussed that you feel we should be aware of?
If yes, please explain_____

Dental History

Does the patient have a chief concern about their teeth?_____

Date of most recent dental examination:_____

- Yes No Has the patient had a previous orthodontic exam? If so, when_____
- Yes No Has the patient had previous orthodontic treatment? If so, when_____
- Yes No Has the patient's adenoids and/or tonsils been removed?

Does the patient now, or have they every had a history of any of the following (Mark Y for Yes or N for No):

- | | | |
|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Injury to the Teeth/Jaws | <input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Clicking/Popping |
| <input type="checkbox"/> Y <input type="checkbox"/> N Grinding | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Snoring |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sleep Apnea | <input type="checkbox"/> Y <input type="checkbox"/> N Gum Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw Growth Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N Finger/Thumb Sucking | <input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Headaches/Earaches | <input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust | <input type="checkbox"/> Y <input type="checkbox"/> N Missing Teeth |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sensitive Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco Use | <input type="checkbox"/> Y <input type="checkbox"/> N Extra Teeth |

Please elaborate on any items that were circled:_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information no disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I authorize the Orthodontist to share this patient's treatment information with the collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

Signature of patient, guardian or responsible party

Date

Doctor's Initials