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Acct. No. _____

PATIIENT REGISTRATION HISTORY-**CHILD**

Name_____ Date ____/____/____
First Middle Last

Birth Date ____/____/____ Age _____ □ Male □ Female School _____ Grade_____

Home Address _____ Home Phone _____
Street City State Zip

Mother's Name _____ Employer _____ D.O.B ____/____/____

Phone No. _____ Social Security No. ____-____-____ E-Mail _____

Insurance Company Name _____ ID No. _____

Father's Name _____ Employer _____ D.O.B ____/____/____

Phone No. _____ Social Security No. ____-____-____ E-Mail _____

Insurance Company Name _____ ID No. _____

Patient lives with □ Both Parents □ Mother □ Father □ Other __

Referred By? _____

MEDICATIONS CURRENTLY TAKING:_____
_____

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO		YES	NO	
☐	☐	Has patient had a physical exam in the past year?	☐	☐	Has patient had any reactions to any medications?
☐	☐	Is patient presently under a physician's care?	☐	☐	Has patient had his/her tonsils and/or adenoids removed?
☐	☐	Has Patient ever been hospitalized?	☐	☐	Does patient experience fainting or dizzy spells?
☐	☐	Is patient taking any pills, medications or drugs?	☐	☐	Does patient have too high or too low blood pressure?
☐	☐	Has patient ever had major surgery?			

HAS PATIENT BEEN DIAGNOSES OR TREATED FOR:

Yes	No		Yes	No	
☐	☐	Heart problems	☐	☐	Hepatitis
☐	☐	Rheumatic fever	☐	☐	Diabetes
☐	☐	Lung problems	☐	☐	Malignancies
☐	☐	Liver problems	☐	☐	Anemia
☐	☐	Endocrine problems	☐	☐	Arthritis
☐	☐	Prolonged Bleeding	☐	☐	Bone
☐	☐	Tuberculosis	☐	☐	Asthma
☐	☐	Herpes	☐	☐	Aids

PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

☐Aspirin ☐Codeine ☐Penicillin ☐Sulfa ☐Latex ☐Metals

☐ Other _____

Dr. Notes:

MEDICAL ALERT
Yes No

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

DENTAL HISTORY

DENTIST NAME _____ PHONE _____ DATE OF LAST CLEANING ____/____/____

Yes	No		Yes	No	
☐	☐	Has patient ever had orthodontic consultation or treatment?	☐	☐	Does patient grind or clench his/her teeth
☐	☐	Has patient been informed of any missing teeth?	☐	☐	Does patient have pain or clicking of the jaw?
☐	☐	Have any permanent teeth been removed by extraction?	☐	☐	Has patient ever had any teeth injured by due to an accident?
☐	☐	Has a family member had orthodontic treatment? Who?_____	☐	☐	Has patient ever had pains in the face?
☐	☐	Does patient breathe predominately trough his/her mouth?	☐	☐	Has patient ever had severe jaw or head injury?
☐	☐	Does patient have any speech problems?			
☐	☐	Does patient now suck his/her thumb or finger?	☐	☐	Does patient's gums bleed when brushing or flossing?

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

Parent/Guardian _____ Date ____/____/____