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creating beautiful faces, one glowing smile at a time

PATIENT REGISTRATION FORM (Please Print)

Federal and state laws require us to obtain the following confidential information with 2 forms of identification. Also, to give you the best consideration of your orthodontic needs and to thoroughly diagnose any condition, we must have accurate background and health information. Please circle the appropriate response where indicated. Thank you.

PATIENT INFORMATION

Patient Name: _____ Age: _____ Birth date: _____ Sex: M F
Home Address: _____
City: _____ State: _____ Zip: _____
Primary Phone: ( ) _____ H W C Alternate Phone: ( ) _____ H W C
Family Dentist: _____ Phone: ( ) _____ Family Physician: _____
Referred by: _____ Email (appointment notification: _____

Primary Personal Responsible for Account: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Occupation: _____ Email: _____
Employer Name & Address: _____
Is patient covered by insurance for orthodontic treatment under this person? Yes No
If "Yes", name of insurance carrier: _____
ID Number: _____ Group Number: _____

Secondary Personal Responsible for Account: _____ Relationship: _____
Date of Birth: _____ Social Security Number: _____
Home Address (if different from patient): _____
Occupation: _____ Email: _____
Employer Name & Address: _____
Is patient covered by insurance for orthodontic treatment under this person? Yes No
If "Yes", name of insurance carrier: _____
ID Number: _____ Group Number: _____

MINOR PATIENT'S FAMILY HISTORY

Patient lives with _____ Relationship to patient: _____
If a minor: Father's Name: _____ Mother's Name: _____
Siblings: None # of Brothers: _____ # of Sisters: _____ Parent's Marital Status: _____

PATIENT'S MEDICAL HISTORY

Has patient ever had:

☐ Asthma	☐ Diabetes	☐ Heart Disease	☐ Hepatitis
☐ Anemia	☐ Epilepsy	☐ Hearing Disease	☐ Rheumatic Fever
☐ Blood Disease	☐ Endocrine Problems	☐ Head or Face Injury	☐ AIDS
☐ Blood Disorder	☐ Emotional Problems	☐ Herpes	☐ Other, describe below

Comments: _____
Has the patient been under the care of a physician during the past two years, other than for routine examinations? Yes No
Condition: _____
Present drugs or medication: _____
Birth Defects: _____ Has the patient reached puberty? (menstruation, pubic hair)? Yes No

-continued-

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RESPIRATORY HISTORY Does the patient:

1. Have allergies to: Seasonal Grasses? _____ Food? _____
   Drugs? _____ Other? _____
2. Snore while sleeping? Yes ○ No ○
3. Mouth breather? Yes ○ No ○
4. Have frequent colds? Yes ○ No ○
5. Have frequent stuffy nose? Yes ○ No ○
6. Have frequent sore throat or tonsillitis? Yes ○ No ○
7. Have chewing or swallowing difficulties? Yes ○ No ○

DENTAL HISTORY

Does the patient have pain or clicking in jaw joint? Yes ○ No ○

Have any teeth been injured due to accidents or blows to the mouth? Yes ○ No ○

Date and details of injury: _____

Has the patient received or requested to receive speech correction? Yes ○ No ○

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

Thumb or finger sucking? Yes ○ No ○ Grinding of teeth? Yes ○ No ○

Lip biting or sucking? Yes ○ No ○ Tongue thrust? Yes ○ No ○

Others (specify): _____

Has the patient had any unusual dental experiences?

Specify: _____

Date of last dental check: _____ Were the patient's teeth cleaned? Yes ○ No ○

ORTHODONTIC HISTORY

Has the patient had a previous orthodontic consultation? Yes ○ No ○

Has the patient had previous orthodontic treatment? Yes ○ No ○

Date: _____ Doctor: _____

Orthodontic consultation prompted by?

☐ Patient ☐ Dentist ☐ Mother ☐ Father ☐ Spouse ☐ Siblings ☐ Physician ☐ Friend

Other (specific): _____

Patient's interest in orthodontic treatment:

☐ Excited about starting treatment ☐ Neutral about treatment ☐ Against having treatment

What prompted this consultation? _____

What is the primary concern? _____

What is expected from orthodontic treatment? _____

Additional comments you wish to make: _____

_____

_____

Signature of individual completing this form: _____

Relationship to patient: _____ **Today's Date:** _____

CLICK TO PRINT FORM