



REGISTRATION AND HISTORY

DATE _____

PATIENT
 RESPONSIBLE PARTY
 FAMILY
 INSURANCE
 REFERRAL

PATIENT'S NAME _____ PREFERRED NAME _____
 DATE OF BIRTH _____ AGE _____ SEX M F PHONE# _____
 STREET _____ CITY/STATE/ZIP _____
 SCHOOL _____ GRADE _____
 EMAIL ADDRESS _____
 EMPLOYER _____ OCCUPATION _____ HOW LONG _____

RESPONSIBLE PARTY _____ S.S.# _____ DOB _____
 ADDRESS _____ CITY/STATE/ZIP _____
 HOME PHONE # _____ BUSINESS/CELL PHONE # _____
 EMAIL ADDRESS _____
 EMPLOYER _____ OCCUPATION _____ HOW LONG _____

ANY MEMBERS OF YOUR FAMILY PATIENTS PRESENTLY OR IN THE PAST? YES NO
 NAMES _____

DO YOU HAVE DENTAL INSURANCE? YES NO
 WHO IS THE PRIMARY INSURANCE CARRIER? PATIENT FATHER MOTHER
 INSURANCE COMPANY _____ PHONE _____
 NAME OF SUBSCRIBER _____ S.S.# _____
 ADDRESS _____ PHONE _____
 BIRTH DATE _____ EMPLOYER _____

PLEASE NOTE: YOU ARE RESPONSIBLE TO NOTIFY US OF ANY CHANGES IN YOUR INSURANCE & WILL BE FINANCIALLY RESPONSIBLE FOR ANY PORTION THE INSURANCE DOES NOT COVER.

PATIENTS DENTIST _____ DATE OF LAST CLEANING? _____
 REFERRED BY DENTIST? YES NO
 WHOM MAY WE THANK FOR YOUR REFERRAL TO OUR OFFICE? _____, OR
 HOW DID YOU HEARD ABOUT US: INTERNET PHONE BOOK NEWSPAPER / MAGAZINE

DENTAL HISTORY

PLEASE ANSWER ALL QUESTIONS:

	YES	NO		YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?.....	<input type="checkbox"/>	<input type="checkbox"/>
HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____	<input type="checkbox"/>	<input type="checkbox"/>	HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?.	<input type="checkbox"/>	<input type="checkbox"/>
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____	<input type="checkbox"/>	<input type="checkbox"/>	HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?....	<input type="checkbox"/>	<input type="checkbox"/>
IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE?	<input type="checkbox"/>	<input type="checkbox"/>	LIST MUSICAL INSTRUMENTS PLAYED: _____		
WHILE ASLEEP?.....	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HISTORY

PATIENT'S PHYSICIAN _____ ADDRESS _____

DATE OF LAST PHYSICAL EXAM _____ RESULTS _____

PLEASE ANSWER ALL QUESTIONS:

	YES	NO		YES	NO
DOES PATIENT HAVE A HEALTH PROBLEM?.....	<input type="checkbox"/>	<input type="checkbox"/>	IS PATIENT ALLERGIC TO ANYTHING (FOOD, POLLEN, ANIMALS, DUST)?	<input type="checkbox"/>	<input type="checkbox"/>
HAS PATIENT BEEN ILL RECENTLY?.....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, WHAT? _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS PATIENT BEEN UNDER TREATMENT BY A PHYSICIAN RECENTLY	<input type="checkbox"/>	<input type="checkbox"/>	DOES PATIENT HAVE ASTHMA?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, FOR WHAT REASON? _____			DOES PATIENT HAVE A HEART PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>
HAS PATIENT BEEN A PATIENT IN A HOSPITAL?.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES PATIENT BLEED EXCESSIVELY WHEN CUT?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, FOR WHAT REASON? _____			DOES PATIENT HAVE AN EMOTIONAL, MENTAL OR NERVOUS PROBLEM?	<input type="checkbox"/>	<input type="checkbox"/>
DOES PATIENT TAKE ANY MEDICINES?	<input type="checkbox"/>	<input type="checkbox"/>	IS PATIENT EITHER PHYSICALLY HANDICAPPED OR MENTALLY RETARDED?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHAT KIND? _____			DOES PATIENT HAVE GOOD PHYSICAL COORDINATION?....	<input type="checkbox"/>	<input type="checkbox"/>
HAS PATIENT EVER REACTED TO ANY MEDICINE, SUCH AS PENICILLIN, ASPIRIN, LOCAL ANESTHESIA (DENTAL INJECTION)?	<input type="checkbox"/>	<input type="checkbox"/>	HAS PATIENT EVER HAD BLOOD OR BLOOD PRODUCT TRANSFUSION?.....	<input type="checkbox"/>	<input type="checkbox"/>

HAS PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS? CHECK ONLY WHAT APPLIES.

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> LUNG | <input type="checkbox"/> DIABETES | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> COUGHING |
| <input type="checkbox"/> MALIGNANCIES | <input type="checkbox"/> KIDNEY | <input type="checkbox"/> T.B. | <input type="checkbox"/> MUMPS | <input type="checkbox"/> WEIGHT LOSS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> LIVER | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> MEASLES | <input type="checkbox"/> FATIGUE |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> EYE INFECTIONS | <input type="checkbox"/> NIGHT SWEATS |
| <input type="checkbox"/> CONVULSION | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> BLEEDING | <input type="checkbox"/> EAR INFECTIONS | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> CHRONIC SINUS | <input type="checkbox"/> SICKLE CELL | <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> HEPATITIS |

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES?

- | | | |
|-----------------------------------|--|-------------------------------|
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> T.B. |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> AIDS |

HAS YOUR PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR HEALTH?.....

YES NO

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

I UNDERSTAND THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN THE MEDICAL STATUS. I ALSO AUTHORIZE THE STAFF TO PERFORM THE NECESSARY SERVICES NEEDED FOR MY CHILD/SELF.

DATE

PATIENT / PARENT SIGNATURE