Orthodontic Registration Form

Thank you for taking the time to complete this form before your first visit. We look forward to meeting you!

Adolescent Patient Information

Full Name (First, M.I., Last Name) _____ Preferred Name _____

Birthday _____ Age _____ Sex ❑ Female ❑ Male School _____

Mailing Address (Street, City, State, Zip) _____ Grade _____

Sibling's Name _____ Age _____ Sibling's Name _____ Age _____

Have other family members been treated in office? If yes who? _____ Hobbies/Sports _____ Musical Instruments _____

Dentist _____ Date of last dental visit _____

General Information

What concerns do you or your child have about their teeth? _____

Has another orthodontist been consulted or previous orthodontic treatment been provided? ❑ Yes ❑ No

If yes, what work has been completed and by whom? _____

Please list any family history of orthodontics/jaw problems: _____

How did you hear about our office? ❑ Dentist ❑ Friend ❑ Other _____

Appointment Reminders (Preferred Text or Email) _____

Parent Guardian Information

Custodial Parent(s) Name(s) _____ Who is financially responsible for this account _____

Patient lives with: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Grandparent(s) ❑ Other _____

Parent/Guardian 1

Name (First, M.I., Last Name) _____ ❑ Dr. ❑ Mrs. ❑ Mr. ❑ Ms. ❑ Other _____ Title

Email Address _____ Cell Phone _____ Home Phone _____

Mailing Address (Street, City, State, Zip) _____

Employer _____ Occupation _____

Birthday _____ Relationship to Patient _____

Dental/Orthodontic Insurance Company _____ SSN _____

Parent/Guardian 2

Name (First, M.I., Last Name) _____

❑ Dr. ❑ Mrs. ❑ Mr. ❑ Ms. ❑ Other_____
Title

Email Address _____

Cell Phone _____

Home Phone _____

Mailing Address (Street, City, State, Zip) _____

Employer _____

Occupation _____

Birthday _____

Relationship to Patient _____

Dental/Orthodontic Insurance Company _____

SSN _____

Dental History

❑ None of These

❑ Bleeding Gums
❑ Blisters on Lips/Mouth
❑ Periodontal Treatment
❑ Finger/Thumb Habit
❑ Grinding Teeth
❑ Tongue Habit/Thrust
❑ Lips/Cheek Biting
❑ Extracted Primary (Baby) Teeth That Were Not Loose
❑ Injuries to Teeth/Jaw
❑ Erupting Teeth Very Early Or Very Late
❑ Mouth Breathing
❑ Gums Sore/Swollen
❑ Dry Mouth
❑ Injuries to Face/Head
❑ Jaw Pain/Tenderness (Bilateral, Right Side, Left Side)
❑ Jaw Lock Open/Closed
❑ Jaw Clicking/Popping (Bilateral, Right Side, Left Side)
❑ Speech Problems
❑ Extracted Permanent Teeth

How often does the patient brush?_____

Hand used to brush teeth_____

Additional Comments:

How often does the patient floss?_____

How would you rate patient's overall dental health?

Poor ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 Great

Medical History Form

❑ None of These

❑ AIDS/HIV+
❑ Anemia
❑ Arthritis
❑ Artificial Heart Valves
❑ Artificial Joints
❑ Asthma
❑ Bleeding Disorders
❑ Bone Disorders
❑ Cancer
❑ Chemotherapy
❑ Circulatory Problems
❑ Cortisone Treatment
❑ Coughing/Persistent
❑ Cough Up Blood
❑ Diabetes
❑ Emotion, Sensory or Developmental Issues
❑ Endocrine Problems
❑ Epilepsy
❑ Fainting
❑ Frequent Headaches or Migraines
❑ Glaucoma
❑ Heart Murmur
❑ Heart Problems
❑ Hemophilia
❑ Hepatitis
❑ High Blood Pressure
❑ Kidney Disease
❑ Liver Disease
❑ Pacemaker
❑ Psychiatric Care
❑ Radiation Treatment
❑ Respiratory Disease
❑ Rheumatic Fever
❑ Stroke
❑ Stomach Ulcer
❑ Thyroid Problems
❑ Tobacco Use
❑ Tonsillitis
❑ Tonsils Removed
❑ Tuberculosis (TB)
❑ Shortness of Breath

Pediatric Sleep Questionnaire

Previous diagnosis of Obstructive Sleep Apnea? ❑ Yes ❑ No Do they snore loudly? ❑ Yes ❑ No

Do they often feel tired, fatigued or sleepy during the daytime? ❑ Yes ❑ No

Have you ever observed them stop breathing or choking/gasping during sleep? ❑ Yes ❑ No

Are they being treated for high blood pressure? ❑ Yes ❑ No

General Health Information

Is the patient under the care of a physician? ❑ Yes ❑ No If yes, please describe:_____

Does the patient smoke or chew tobacco? ❑ Yes ❑ No Female: Is it possible the patient is pregnant? ❑ Yes ❑ No

Has the patient ever taken a bisphosphonate medication, such as: Aclasta, Actonel, Actonel+Ca, Aredia, Ateliva, Binosta, Bonefos, Boniva, Didronel, Fosamax +D, Reclast, Skelid, or Zometa? ❑ Yes ❑ No Additional Comments:_____

Does the patient have an allergy or sensitivity to Latex, Metals, or Plastics? ❑ Yes ❑ No

Has the patient ever required antibiotics (Pre-medication) prior to a dental visit? ❑ Yes ❑ No

How would you rate the patient's overall physical health? Poor ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Great

Medications: Please list any and all medications the patient is currently taking. _____

Allergies: Please list any and all known allergies. _____

I understand the information provided today is correct to the best of my knowledge. This information will be held in the strictest confidence, and I understand it is my responsibility to inform this office of any changes in my child's medical status. I understand that it is the office's policy to scan and store original documents in electronic form. I acknowledge that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

_____ _____

Parent/Guardian Signature Date