braced ORTHODONTICS

CHILD REGISTRATION

PATIENT INFORMATION

Patient Name:		Sex: ○ M / ○ F	DOB:	
SSN:	Age:		Email:	
Mailing Address:	City:		State:	Zip Code:
Home #:	Cell #:		Name of Personal Responsible for Account:	
Mother/Guardian Name:	Mother/Guardian SSN:		Mother DOB:	
Father/Guardian Name:	Father/Guardian SSN:		Father DOB:	

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Address:
Phone #:	Relationship to Patient:

DENTAL INSURANCE INFORMATION

Insurance Name:	Member ID #:	Group #:
Policy Holder's Information: Name: DOB: SSN:		
Name & Address of Policy Holder's Employer:		

OTHER INFORMATION

How did you hear about our office?

DENTAL HISTORY

Please check any of the following that apply:

- ☐ Crowded Teeth
- ☐ Narrow Jaws
- ☐ Underbite
- ☐ Overbite
- ☐ Jaw Joint Pain
- ☐ Grinding or Clenching Teeth
- ☐ Migraines
- ☐ Uses/Used Pacifier
- ☐ Uses/Used Sippy Cup
- ☐ Sucks/Sucked Thumb or Fingers
- ☐ Breastfed
- ☐ Bottlefed
- ☐ Had orthodontics previously
- ☐ Has/had many cavities
- ☐ Has/had gum disease

Current Dentist: _____
City/State: _____
Phone #: _____
Last Cleaning: _____
Last Xrays: _____

If you could change your child's smile, would you:

- ☐ Make their teeth whiter
- ☐ Make their teeth straighter
- ☐ Close spaces
- ☐ Make smile wider
- ☐ Fix overbite/underbite
- ☐ Stop habit

What is most important to you about your child's future smile?

_____

What is most important to you about your child's visit today?

_____

MEDICAL HISTORY

Is your child currently under a physician's care? ○ Yes ○ No For what? _____

Physician: _____ Phone#: _____

Please check any of the following that apply to your child:

- ☐ Acid Reflux
- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Back Problems
- ☐ Behavior Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Difficult Swallowing
- ☐ Epilepsy/Seizures
- ☐ Headaches/Migraines
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Respiratory Problems
- ☐ Restless Sleep
- ☐ Ringing/Buzzing of Ears
- ☐ Scarlet Fever/Strep
- ☐ Sleep Apnea/Snoring
- ☐ Speech Problems
- ☐ Stomach Ulcer/ U.C.
- ☐ Tonsils/Adenoids Removed
- ☐ Tubes in Ears

Is your child allergic to any of the following?

- ☐ Nickel
- ☐ Other Metals
- ☐ Antibiotic
- ☐ Latex

Please list major surgeries your child has had:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

What medications is your child taking?

_____
_____
_____
_____

I certify that the information about my child's medical history is correct, to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____