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

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 ____

Has any other member of the family been treated in our 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 orthodontic/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) ______________________ Title ☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Other __________

Email Address __________ Mailing Address __________ Cell Phone __________

Home Phone __________ Employer __________ Occupation __________

Birthday __________ Relationship to Patient __________ Dental/Orthodontic Insurance (Company) __________ SSN __________

Parent/Guardian 2

Name (First, M.I., Last Name) ______________________ Title ☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Other __________

Email Address __________ Mailing Address __________ Cell Phone __________

Home Phone __________ Employer __________ Occupation __________

Birthday __________ Relationship to Patient __________ Dental/Orthodontic Insurance (Company) __________ SSN __________

Dental History — Check if your child has or has had any of the following:

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

How often does the patient brush?__________ How often does the patient floss?__________

Hand used to brush teeth __________ How would you rate the patient's overall dental health? Poor < 0 1 2 3 4 5 > Great

Additional Comments: __________

Medical History Form — Check if your child has or has had any of the following:

- ☐ 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 Females: 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, 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 & all medications the patient is currently taking. __________

Allergies: Please list any & 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

__________ Changes __________ Date