Patient Registration and Health History Questionnaire

1. Tell us about your child

Today's date: ___________ Nickname: ________________________

Child's Name: ________________________________
Last First MI

Birthdate: ____/____/____ Age: _______ ☐ Male ☐ Female

Hobbies / Sports: ____

Child's Home #: (____) ______________________________________

Child's Home Address: ______________________________________

____
City State Zip

2. Who is accompanying your child today?

Name: ______________________________ Relation: _____________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? ___________________________

List brother(s) / sister(s) with age and D.O.B: ______________________

____

General Dentist: ____
Last Visit Date: ____

Parent's Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

3. ☐ Mother's Information ☐ Stepmother ☐ Guardian

Name: __________________________ Birthdate: _____/_____/_____

Wk# (____) ______________ Ext: _____ Hm#: (____) ___________

SS#______________________________ Cell# ___________________
E-mail Address: ____

Employer: ____

Employer Address: ____

How long at current job? _______ ☐ year(s) ☐ month(s)

☐ Father's Information ☐ Stepfather ☐ Guardian

Name: __________________________ Birthdate: _____/_____/_____
Wk#: (____) ______________ Ext: _____ Hm#: (____) ___________

SS# ______________________________ Cell#___________________
E-mail Address: ____
Employer: ____

Employer Address: ____

How long at current job: _______ ☐ year(s) ☐ month(s)

4. Primary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #: (_____) ____________________________

Group/Policy #: ____

Policy Owner's Name: _____________________________________

Relationship to Patient: ____________________________________

Policy Owner's Birthdate: _____/_____/_____

Policy ID#: ____

Home Address (if different than patient): _______________________

____

5. Secondary Orthodontic Insurance

Orthodontic Coverage? ☐ Yes ☐ No
Insurance Co. Name: ______________________________________

Insurance Co. Address: ____________________________________

Insurance Co. Phone #: (_____) ____________________________

Group/Policy #: ____

Policy Owner's Name: _____________________________________

Relationship to Patient: ____________________________________

Policy Owner's Birthdate: _____/_____/_____

Policy ID#: ____

Home Address (if different than patient):_______________________

____

6. Person Responsible for Account

Name: ________________________ Relationship______________

Home Address (if different than patient): _______________________
____

Hm # (____) _________________ Wk# (____) ________________

Continue on back please….

7. *What are the main concerns that you would like orthodontics to accomplish?* _______________

____

Has your child ever taken Phen-Fen? ☐ Yes ☐ No
(Also known as Redux or Pondimin) If yes, when? ________________________

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played: ____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her Jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: ____

Phone #: (____)________________________ Date of last visit? __________________

Is your child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (Girls) ☐ Yes ☐ No

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: ________________________

____

Please list all drugs / things that your child is allergic to: _______________________

____

Y ___ **N**___ Latex **Y** ___ **N** ___ Metals/Nickel **Y** ___ **N**___ Plastics

8. *Has your child ever had any of the following medical problems?*

Y N Abnormal bleeding	Y N Convulsions / Epilepsy
Y N ADD / ADHD	Y N Diabetes
Y N Allergies to any drugs	Y N Handicaps / disabilities
Y N Allergic to latex / metals	Y N Hearing impairment
Y N Allergic to plastic	Y N Heart murmur
Y N Any hospital stays	Y N Hemophilia
Y N Any operations	Y N Hepatitis
Y N Artificial bones / joints / valves	Y N HIV+ / AIDS
	Y N Kidney / Liver problems
Y N Asthma	Y N Lupus
Y N Congenital heart defect	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

____

____

9. *Has your child ever experienced any of the following?*

Y N Clenching / grinding teeth	Y N Nursing bottle habits
Y N Lip sucking / biting	Y N Speech problems
Y N Mouth breather	Y N Thumb / Finger sucking
Y N Nail biting	Y N Tongue thrust

Neighbor or Relative not living with you.

Name ______________________ Phone # (___)______________

Address ____

____

City State Zip

10. I understand that the information that I have 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 my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of parent or guardian Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

____

Signature of parent or guardian Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

____

Signature of parent or guardian Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein. Initials: ________ Date: ______________