GRAND RIVER ORTHODONTICS

Comprehensive Patient Registration Record
And Health History
All information listed is
STRICTLY CONFIDENTIAL

## Patient Information - Youth

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ M ☐ F Birth Date: _____ Age: _____ School: _____ Grade Level: _____

Patient Address: _____
Street Apartment # City State Zip Code

Home Phone: _____ Email: _____

Parent Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed # of Siblings: _____

Name of Patient's General or Pediatric Dentist: _____

Do you have family members that come to our office? _____

Who can we thank for referring you? _____

Name and relationship of emergency contact: _____

Alternate emergency contact and phone number (**NOT a parent**) : _____

## Parent Information

| **Father** | **Mother** |
|---|---|
| Name: _____ | Name: _____ |
| Birthdate: _____ | Birthdate: _____ |
| Home Address: _____ | Home Address: _____ |
| Home Phone #: _____ | Home Phone #: _____ |
| Cell #: _____ | Cell #: _____ |
| Email: _____ | Email: _____ |
| Occupation: _____ | Occupation: _____ |
| Employer: _____ | Employer: _____ |
| Employer Address: _____ | Employer Address: _____ |
| Business Phone #: _____ | Business Phone #: _____ |
| Social Security #: _____ | Social Security #: _____ |
| How long at current job: _____ | How long at current job: _____ |

## Responsible Party Information

Name: _____

Gender: ☐ M ☐ F Relationship to patient: _____ Birthdate: _____

Phone (Home): _____ (Mobile): _____ (Work): _____ *Circle Preferred Contact #*

Address: _____
Street Apartment # City State Zip Code

Previous Address (if at current address less than 3 years): _____
Street Apartment # City State Zip Code

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____ Years at this job: _____

Work Address: _____
Street Apartment # City State Zip Code

## Insurance Information

| Primary Dental Insurance | Secondary Dental Insurance |
|---|---|
| Orthodontic Coverage? ☐ Yes ☐ No | Orthodontic Coverage? ☐ Yes ☐ No |
| Insured's Name: _____ | Insured's Name: _____ |
| Relationship to Patient: _____ | Relationship to Patient: _____ |
| Insured's Birthdate: _____ | Insured's Birthdate: _____ |
| Insured's Employer: _____ | Insured's Employer: _____ |
| Insurance Co. Name: _____ | Insurance Co. Name: _____ |
| Subscriber ID#: _____ | Subscriber ID#: _____ |
| Insurance Co. Group#: _____ | Insurance Co. Group#: _____ |
| Insurance Co. Address: _____ | Insurance Co. Address: _____ |
| _____ | _____ |
| Insurance Co. Phone #: _____ | Insurance Co. Phone #: _____ |

## Medical History

Please indicate whether or not the patient has ever had any of the following medical conditions or treatment by circling (Y)es or (N)o.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Y | N | ADD/ADHD | Y | N | Fainting or dizzy spells | Y | N | Migraine headaches |
| Y | N | Anemia | Y | N | Fever blisters or herpes | Y | N | Neurologic problems |
| Y | N | Arthritis or joint swelling | Y | N | Gastrointestinal problems | Y | N | Organ donor |
| Y | N | Artificial bones/joints/valves | Y | N | Growth problems | Y | N | Organ transplant |
| Y | N | Asthma | Y | N | Hearing impairment | Y | N | Osteoporosis or weak bones |
| Y | N | Blood disorder | Y | N | Heart attack or stroke | Y | N | Persistent cough (>3wks) |
| Y | N | Bone disorders | Y | N | Heart catheter/stent/pacemaker | Y | N | Radiation or chemotherapy |
| Y | N | Cancer | Y | N | Heart murmur | Y | N | Rheumatic/scarlet fever |
| Y | N | Compromised immune system | Y | N | Hemophilia/prolonged bleeding | Y | N | Sickle cell disease/trait |
| Y | N | Congenital heart defect | Y | N | Hepatitis or liver problems | Y | N | Sinus problems |
| Y | N | Convulsions/epilepsy/seizures | Y | N | High or low blood pressure | Y | N | Skin disorder or rash |
| Y | N | Delayed or prolonged healing | Y | N | HIV/AIDS | Y | N | Thyroid disease-hypo or hyper |
| Y | N | Depression | Y | N | Hormone replacement | Y | N | Tinnitus/ringing in the ear |
| Y | N | Diabetes | Y | N | Jaundice | Y | N | Tuberculosis |
| Y | N | Drug/alcohol abuse | Y | N | Kidney problems | Y | N | Vision problems |
| Y | N | Ear aches | Y | N | Learning disability | Y | N | Tonsils removed Age:____ |
| Y | N | Endocrine problems | Y | N | Lung disease | Y | N | Adenoids removed Age:____ |
| Y | N | Emotional/psychological problems | Y | N | Lupus | Y | N | Immunizations |

Female only: Y N Pregnant
Female only: Y N Started menstruation If yes, age: _____
Male only: Y N Voice change If yes, age: _____

Allergies: Y N Medications If yes, please list: _____
Y N Latex Y N Metals Y N Plastic/acrylic Y N Nuts, other foods, or dyes

Are you currently being seen for an injury or illness? Y N If yes, explain: _____

Have you ever been hospitalized? Y N If yes, explain: _____

Are there any other medical concerns we should be aware of? Y N If yes, explain: _____

Physician's Name: _____ Phone: _____ Date of last physical: _____

Please list any medication(s), prescription and over the counter, currently being taken along with the reason:
_____ Reason: _____
_____ Reason: _____
_____ Reason: _____

## Dental History

Please indicate whether or not the patient has ever had any of the following by circling (Y)es or (N)o.

| | | | |
|---|---|---|---|
| Y | N | Injury to the face, mouth, or teeth | If yes, explain _____ |
| Y | N | Thumb, finger, or lip sucking habit | If yes, current or discontinued at what age? _____ |
| Y | N | Tongue thrust problem | |
| Y | N | Mouth breathing | If yes, day, night, or both? _____ |
| Y | N | Missing permanent teeth | |
| Y | N | Extra permanent teeth | |
| Y | N | Teeth removed by extraction | If yes, when? _____ |
| Y | N | Clenching or grinding of teeth | If yes, day, night or both? _____ |
| Y | N | Pain, popping, or locking on jaw opening or closing | |
| Y | N | Difficulty opening | |
| Y | N | Treatment for TMJ or jaw joint problems | If yes, explain _____ |
| Y | N | Frequent headaches | |
| Y | N | Muscle tenderness or stiffness in the jaw or neck | |
| Y | N | Speech issues | |
| Y | N | Cleft lip and/or palate | |
| Y | N | Dry mouth | |
| Y | N | Abscess or cyst | |
| Y | N | Gum surgery | If yes, explain _____ |
| Y | N | Periodontal disease | |
| Y | N | Dental emergencies | If yes, explain _____ |
| Y | N | Previous orthodontic evaluation or treatment | If yes, explain _____ |

Date of last dental visit: _____ Date of last cleaning at the dentist: _____

What are your chief concerns and what would you like to accomplish with orthodontic treatment?

_____

_____

_____

_____

_____

_____

_____

I understand that the information that I have given in the comprehensive patient registration record and health history is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in this information including changes in medical history, dental history, and medications. I will not hold anyone at Grand River Orthodontics responsible for any errors or omissions made in the completion of this form. I grant permission for my health care providers to be contacted when deemed necessary. This office reserves the right to verify 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. I have read and understood this paragraph and I authorize Grand River Orthodontics to perform a complete orthodontic evaluation (may include xrays and photographs as necessary at no charge).

_____

Signature of parent or guardian Date

_____

Printed name