CHILD REGISTRATION

PATIENT INFORMATION:

Patient's Name: _____ Date:_____
Address:_____
Age:_____ Birthday:_____ Attends school at: _____ Grade: _____
Name/Age of siblings: _____
Who may we thank for sending you to our office? _____

Father's name: _____ Mother's name: _____
Address: _____ Address: _____
_____ _____
Phone: (home) _____ Phone: (home) _____
Work: _____ Cell: _____ Work: _____ Cell: _____
Email: _____ Email: _____
Employment: _____ Employment: _____
ss#: _____Date of Birth:_____ ss#: _____Date of Birth: _____

DENTAL INSURANCE:

Dental Ins. Co. _____ Address**: _____**
Phone: _____ Subscriber name:_____

MEDICAL HISTORY:

Family Dentist: _____ City: _____
Physician's Name: _____ City: _____

Are there any general health problems?	YES	NO
Please specify _____		
Has the patient ever been hospitalized or had surgery?	YES	NO
Please specify _____		
Are medications being taken at this time?	YES	NO
Please list _____		
Has the patient had any of the following afflictions?		
HIV?	YES	NO
Heart disease?	YES	NO
Diabetes?	YES	NO
Rheumatic fever?	YES	NO
Epilepsy?	YES	NO
Respiratory disease?	YES	NO
Prolonged bleeding?	YES	NO
Hepatitis?	YES	NO
Allergy to any drugs?	YES	NO
Please list _____		
Healing complications?	YES	NO
Ear problems?	YES	NO
Nervous or mental disorder?	YES	NO
Kidney or liver disease?	YES	NO

CONSENT: It is necessary for parent/guardian to sign permission before any necessary dental service is started for a minor. I grant Dr. Linda Powers permission to provide my child's dental exam and treatment. I will be responsible for the cost of dental care, including attorney fees and court costs that may be necessary to collect any outstanding balance on this account. I, by virtue of my signature on this document, agree to bind myself, the patient and my spouse and we jointly and severally agree to be responsible for treatment for the patient named above and understand the billing will be made jointly and the responsibility of the account is joint and severally. In filing bankruptcy proceedings, either voluntary or involuntary, Dr. Linda Powers reserves the right to terminate all future treatment and services.

Signed: _____ Date: _____

HISTORY

PATIENT MOTIVATION

What is the patient's chief complaint?

Crooked teeth Facial appearance Bite problems Spacing of front teeth
Joint problems Buck teeth Dentist sent me No idea Other_____

HABITS

Oro-digital habits? Thumb-sucking Finger-sucking Lip-biting

DENTAL HISTORY

Have any of the primary or permanent teeth been extracted? No Yes

Is there a history of accident or trauma to the teeth? No Yes

Periodontal (gum) problems? No Yes

Is the patient a smoker? No Yes

TMJ HISTORY

Does the patient clench or grind the teeth? If yes… clench grind

Pain upon opening, chewing, or headaches or earaches? No Yes
If yes: Which side? Right Left Both

Does the jaw lock upon opening or closing? No Yes

Limitations of movement of the jaw? No Yes

Clicking or popping? No Rare Infrequent Frequent
If yes: Which side? Right Left Both

ENVIRONMENT

Is there difficulty in breathing through the nose? No Yes

Have the tonsils and/or adenoids been removed? No Yes

Were there any major accidents, falls, trauma, or operations involving the head? No Yes

Is there a history of allergic conditions? If yes: Asthma Hay fever Other

CONGENITAL ANOMALIES If yes…

Cleft lip Cleft palate Congenital heart defects Other craniofacial anomalies (hand, feet)

GROWTH HISTORY (FEMALES ONLY)

Has menarche been reached (girls only)? Not known Irrelevant No Yes
If yes: At what age? _____

Are you taking any bisphosphonate medications (Aredia, Zometa, Boniva, etc)? No Yes

OTHER

Any other factors that you think may affect orthodontic treatment? _____