

CHILD REGISTRATION

CHILD'S DETAILS	GENERAL INFORMATION						
Today's Date: / / / MM DD YYYY	Who is accompanying the child today?						
Name:	Name:						
Last First MI							
Child prefers to be called: DMale DFemale	Relation:						
Birthdate: Age: SS#:	Other Siblings (Names & Ages):						
Home Address:							
Apt/Condo#	General Dentist: Last Visit:						
City State Zip							
Child's Home Tel#:	Dentist's Tel#:						
Sports/Hobbies:	Whom may we thank for referring you?						
RESPONSIBL	E PARTY(S) DETAILS						
☐ Father ☐ Step-Father ☐ Legal Guardian	☐ Mother ☐ Step-Mother ☐ Legal Guardian						
Name:	Name:						
Last First MI Title	Last First MI Title						
Home#: Cell#:							
Work#: Ext:	Work#: Ext:						
Email:	Email:						
Birthdate: MM / DD / YYYY SS#:	Birthdate: / / SS#:						
Home Address (If different to child's):	Home Address (If different to child's):						
Apt/Condo#							
City State Zip	City State Zip						
Employer:	Employer:						
If you have orthodontic insurance coverage	e for the child, please complete the section below:						
Insurance Company:	Insurance Company:						
Group/Plan/Local/Policy#:	Group/Plan/Local/Policy#:						
Insured's ID#:	Insured's ID#:						
Insurance Co. Address:	Insurance Co. Address:						
Apt/Condo#	Apt/Condo#						
City State Zip	City State Zip						
Who will be the responsible party for the account?							
Responsible Party's Marital Status: □Single □ Marr	ied □ Partnered □ Divorced/Separated □Widowed						



	DEN	TAL AND M	EDICAL H	HISTORY				
What are the main concerns that you would like o resolve?	rthodontics	s to	Please li	st all med	ications the child is c			
The child's current physical health is:	I □ Fair	□ Poor			GIC TO ANY OF THE FOL			V. N. Blastia
Has the child ever been evaluated or had orthodontic treatment before?	□ Yes	□No	Y N Y N		Y N Nick nesthetics er allergies:	els/Me	etals	Y N Plastic
Have there ever been any injuries to the child's face, mouth, teeth, or chin?	☐ Yes	□ No						
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?	□ Yes	□ No	HAS THE	CHILD EVE	R HAD ANY OF THE FOL	LOWI	NG MEI	DICAL PROBLEMS?
Does the child require antibiotics before dental treatment?	□ Yes	□ No	Y N Y N Y N	ADD/AI	nal Bleeding DHD V+	Y Y Y		Heart Murmur Hemophilia Hepatitis
Have adenoids or tonsils been removed?	□ Yes	□ No	Y N Y N Y N	Asthma	l Bones/Joints/Valves Chemotheraphy	Y Y Y	N N	Hospitalization/Operation Kidney Problems Liver Problems
Does the child have any missing or extra permanent teeth?	☐ Yes	□No	Y N Y N Y N	Conger	ital Heart Defect sions	Y Y Y		Mitral Valve Prolapse Prosthetics Rheumatic Fever
Does the child brush his/her teeth daily?	☐ Yes	□No	Y N Y N	Epileps: Handica	/ aps/Disabilities	Y Y	N N	Scarlet Fever Sickle Cell Disease/Traits
Does the child floss his/her teeth daily?	☐ Yes	□No	Y N	Hearing	Impairment	Y	N	Tuberculosis (TB)
Has puberty begun?	☐ Yes	□No	Please ex	xplain any	other serious medic	al cor	nditio	n(s) the child has had:
If female, has menstruation begun?	□ Yes	□ No						
Does the child have a personal physician? Physician's Name:	☐ Yes	□ No		anything y George in	ou would like to disc private?	cuss		□ Yes □ No
Physician's Tel#: Last Visits the child currently under the care of a physician If yes, please explain:	MM YY ? □ Yes		DOES/DIE Y N Y N Y N Y N	Clenchi Lip Suc	D EVER EXPERIENCE AN ng/Grinding Teeth king/Biting Breather ng	Y Y	N N N	LLOWING? Speech Problems Thumb/Finger Sucking Tongue Thrusting Pacifier
Our office is HIPAA compliant and is committed to	meeting or	exceeding the s	standards of	infection	control mandated by	the O	SHA, t	he CDC, and the ADA.
I hereby declare that, to the best of my knowled tion will be held in the strictest confidence and						my c		
I hereby declare that I have verbally review named herein.	ved the der	ntal and medic	cal informa	tion abov	ve with the parent/g	juard	lian of	f the patient OF
I hereby declare that I have verbally review named herein. Comments:					ontist Signature			The patient OFFICE USE ONLY
	ME	DICAL HIST	ORY UPI	DATE				
Has there been any change in your child's health sta If yes, please explain:			□ Yes	□No	Parent/Guardian Signature	2		Date
Has there been any change in your child's health sta			□ Yes	□ No	Orthodontist Signature Parent/Guardian Signature	2		Date
If yes, please explain:					Orthodontist Signature			Date



