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 ____ preferred name ____

Birthdate ____ Age ____ ☐ Male ☐ Female

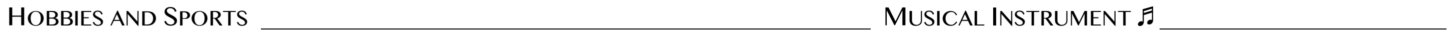
Mailing Address ____ Street ____ city ____ state ____ zip ____

School ____ Grade ____

Patient's Residence ☐ Both Parents ☐ Father ☐ Mother ☐ Other ____

Siblings (name/age) ____

Has any other member of the family been treated in our office? If yes, who? ____



Hobbies and Sports ____ Musical Instrument ♬ ____

Patient's Dentist ____ Date of Last Visit ____

Please tell us how you heard about our practice ☐ Dentist ____

☐ Friend ____

☐ Other ____

Appointment reminders (preferred email) ____

What would you like orthodontic treatment to accomplish? ____

Has another orthodontist been consulted or previous orthodontic treatment been provided? ☐ Yes ☐ No

If yes, what work has been completed and by whom? ____

PARENT/GUARDIAN INFORMATION

** If parents are separated/divorced, please indicate the person who is financially responsible____**

MOTHER'S INFORMATION

☐ Dr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Rev. ☐ S ☐ M ☐ D ☐ W ☐ Other ____

Name ____ first ____ m.i. ____ last ____ Email ____

Address (home) ____ Street ____ city ____ state ____ zip ____

Phone (home) (   ) ____ (mobile) (   ) ____ (work) (   ) ____

Employer ____ Occupation ____ #Yrs ____

Birthdate ____ Relationship to Patient ____

Dental/Orthodontic Insurance (company) ____ SSN ____

FATHER'S INFORMATION

☐ Dr. ☐ Mr. ☐ Rev. ☐ S ☐ M ☐ D ☐ W ☐ Other ____

Name ____ first ____ m.i. ____ last ____ Email ____

Address (home) ____ Street ____ city ____ state ____ zip ____

Phone (home) (   ) ____ (mobile) (   ) ____ (work) (   ) ____

Employer ____ Occupation ____ #Yrs ____

Birthdate ____ Relationship to Patient ____

Dental/Orthodontic Insurance (company) ____ SSN ____

Please provide a copy of your insurance card

Nicholas R. Smith, DDS, MS, PC
Diplomate, American Board of Orthodontics

DENTAL HISTORY

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

☐ Bleeding Gums ☐ Grinding Teeth ☐ Jaw Lock Open/Closed ☐ Pain around Ear
☐ Blisters on Lips/Mouth ☐ Gums Sore/Swollen ☐ Jaw Pain/Tenderness ☐ Periodontal Treatment
☐ Dry Mouth ☐ Injuries to Teeth/Jaws ☐ Lip/Cheek Biting ☐ Periodontal Surgery
☐ Extracted Teeth ☐ Injuries to Face/Head ☐ Loose Teeth ☐ Speech Problems
☐ Finger/Thumb Habits ☐ Jaw Clicking/Popping ☐ Mouth Breathing ☐ Tongue Thrust

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

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

Please list any family history of orthodontic/Jaw problems: ______________________

Additional Comments:

MEDICAL HISTORY

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

☐ AIDS/HIV+ ☐ Circulatory Problems ☐ Heart Murmur ☐ Respiratory Disease
☐ Anemia ☐ Cortisone Treatment ☐ Heart Problems ☐ Rheumatic Fever
☐ Arthritis ☐ Coughing – Persistent ☐ Hemophilia ☐ Stroke
☐ Artificial Heart Valves ☐ Cough Up Blood ☐ Hepatitis ☐ Stomach Ulcer
☐ Artificial Joints ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Problems
☐ Asthma ☐ Endocrine Problems ☐ Kidney Disease ☐ Tobacco Use
☐ Bleeding Disorder ☐ Epilepsy ☐ Liver Disease ☐ Tonsillitis
☐ Bone Disorders ☐ Fainting ☐ Pacemaker ☐ Tonsils Removed
☐ Cancer ☐ Glaucoma ☐ Psychiatric Care ☐ Tuberculosis (TB)
☐ Chemotherapy ☐ Headaches ☐ Radiation Treatment ☐ Shortness of Breath

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 required antibiotics (Pre-Medication) prior to a dental visit? ☐ Yes ☐ No

Does the patient have an allergy or sensitivity to Latex, Metals or Plastics? ☐ Yes ☐ No

Has the patient ever taken a **bisphosphonate medication**, such as: Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa? ☐ YES ☐ NO

How would you rate the patient's overall physical health? Poor < 0 1 2 3 4 5 > Great

Additional Comments:

MEDICATIONS

Please list **ANY & ALL** medications the patient is currently taking:

____

____

ALLERGIES

Please list **ANY & ALL** known allergies you are aware of:

____

____

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:* ______________________

I authorize the release of any information necessary to process the patient's insurance claim and to communicate with other doctors who may be involved in the patient's health care. I understand that prior to extending credit for treatment fees, a credit bureau report may be obtained.

Parent/Guardian Signature: ______________________ *Date:* ______________________

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