



Welcome to our office!

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Orthodontic & Dentofacial Orthopedics

Member
American Association of
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NEW PATIENT REGISTRATION FORM

(FOR PATIENTS UNDER AGE 18)

The information provided is strictly confidential.

www.YourBite.com



PATIENT INFORMATION

Patient's Legal Name: _____ Preferred Name: _____

Today's date: ____ / ____ / ____ Birthdate: ____ / ____ / ____ Age: ____ Sex: M / F

Address: _____ City, State, Zip: _____

Home phone: (____) _____ Email address: _____

Close friend/relative who is a patient here _____

Brothers/Sisters or Sons/Daughters (names/ages): _____

Hobbies/Interests: _____ School/ Grade: _____

Previous orthodontic consultation? Yes / No If so, when/where? _____

Previous orthodontic treatment? Yes / No If so, when/where? _____

In your opinion, what is your orthodontic problem? _____

Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Father's Name: _____ Martial Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home phone: (____) _____ Cell/Work #: (____) _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ____ / ____ / ____

Employed By: _____ Occupation: _____ Years: _____

Mother's Name: _____ Martial Status: S / M / W / D

Home phone: _____ Cell/Work #: _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ____ / ____ / ____

Employed By: _____ Occupation: _____ Years: _____

Email address: _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the noncustodial parent? Yes / No

Do you have orthodontic insurance coverage? Yes / No If yes, please fill out insurance form. Thanks!

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DENTAL INFORMATION

How does the patient feel about wearing "braces": _____

Does anyone else in the family need orthodontics? Yes / No If yes who? _____

Dentist's Name: _____ Does the patient receive regular checkups? Yes / No

Last Dental Exam: _____ Last Dental X-Rays: _____

Other Dental Specialists: _____

Have you been satisfied with past dentistry? Yes / No If No, please explain _____

Does the patient currently have, or have had any of the following? (please circle)

Thumb/finger Habit

Head/neck injury

Nail biting

Jaw/joint pain/head/neck pain

Periodontal disease

Cold sores/clenching/grinding

Gum surgery/food traps

Adult/baby/wisdom tooth extractions

Is the any other dental information we should now about? _____

MEDICAL INFORMATION

Physician's Name: _____ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen): _____

Is the patient currently under medical care? Yes / No Where/When? _____

Is the patient currently taking medications? Yes / No Please list: _____

Has the patient ever been hospitalized? Yes / No Where/When? _____

Does the patient currently have, or have had any of the following? (please circle)

Adenoid removed

Drug history

Major surgery

AIDS (HIV)

Epilepsy/seizures

Nasal/airway problems

Arthritis

Heart problems

Sinus problems

Asthma

Hepatitis A, B or C

Speech problems

Auto accident

High blood pressure

Tobacco usage

Bleeding disorders

Immune disorders

Tonsils removed

Cancer

Kidney problems

Tuberculosis

Cosmetic surgery

Liver problems

Tubes in ears

Diabetes

Lung problems

Venereal disease

Is the any other medical information we should now about? _____

EMERGENCY INFORMATION

Name: _____ Rel. to pt.: _____

Address: _____ City, State, Zip: _____

Home phone: () _____ Cell/Work #: () _____

* Signature: _____ Today's Date: ____ / ____ / ____
(Please sign and date today)

Update signature: _____ Update Date: ____ / ____ / ____