OTAY LAKES ORTHODONTICS

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PATIENT REGISTRATION
HISTORY - CHILD

PATIENT'S NAME _____ DATE ____ / ____ / ____

BIRTH DATE ____ / ____ / ____ ☐ MALE ☐ FEMALE. GRADE ____ HOBBIES_____

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ E-MAIL _____ CELL/PAGER _____

MOTHER'S NAME _____ FATHER'S NAME _____

MOTHER'S EMPLOYER _____ FATHER'S EMPLOYER _____

YEARS EMPLOYED _____ YEARS EMPLOYED _____

OCCUPATION _____SOCIAL SEC# _____ OCCUPATION _____SOCIAL SEC# _____

SIBLINGS _____PATIENT LIVES WITH ☐BOTH PARENTS ☐MOTHER ☐FATHER ☐OTHER

BILLING NAME _____ RELATIONSHIP TO PATIENT_____

BILLING ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ LAST VISIT ____ / ____ / ____

ADDRESS _____ MEDICAL ID#_____
(STREET) (CITY) (STATE) (ZIP)

YES	NO	
☐	☐	Has patient undergone a physical exam in the past year?
☐	☐	Is patient presently under a physician's care?
☐	☐	Has patient ever had a major surgery?
☐	☐	Has patient ever been hospitalized?
☐	☐	Is patient taking any pills, medication or drugs?
☐	☐	Is patient allergic to Novocain or penicillin?
☐	☐	Has patient had any unusual reaction to any medication?
☐	☐	Has patient had tonsils and/or adenoids removed?
☐	☐	Does patient have fainting or dizzy spells?
☐	☐	Does patient have a too high or low blood pressure?

Has patient ever been diagnosed or treated for the following?

YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Hepatitis
☐	☐	Kidney Problems	☐	☐	Rheumatic Fever
☐	☐	Lung Problems	☐	☐	Emotional Problems
☐	☐	Liver Problems	☐	☐	Malignancies
☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Diabetes	☐	☐	Bone Problems
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding
☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Asthma

Are there any other medical problems I should be aware of? _____

IF YES, PLEASE EXPLAIN_____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

DATE OF LAST CLEANING ____ / ____ / ____ ANY PENDING WORK? _____

WHAT IS THE MAJOR CONCERN ABOUT PATIENT'S TEETH? _____

YES	NO	
☐	☐	Has patient had previous orthodontic consultation or treatment?
☐	☐	Has patient ever been informed of any extra or missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Has any family member had orthodontic treatment? Who? _____
☐	☐	Does patient currently suck his/her thumb or finger?
☐	☐	Have any teeth been injured or chipped due to an accident?
☐	☐	Is patient concerned about the appearance of his/her teeth?

YES	NO	
☐	☐	Does patient grind or clench his/her teeth?
☐	☐	Does patient have pain or clicking of the jaw joint?
☐	☐	Does patient breathe predominantly through the mouth?
☐	☐	Does patient ever have pains in the face or head?
☐	☐	Has patient ever had severe jaw or head injury?
☐	☐	Do patient's gums bleed on brushing or flossing?
☐	☐	Does patient have any speech problems?
☐	☐	Does patient want his/her teeth straightened?

Are there any other dental/orthodontic problems I should be aware of? _____

Parent/Guardian Signature _____ Date _____