

Child / Adolescent Orthodontic Registration

General Patient Information

Name: _____ Date Of Birth: ____/____/____

Address/City/Zip: _____

Nickname: _____ Phone: _____ Sex: M F

School: _____ Grade: _____

Hobbies/Sports/Musical: _____

General Dentist: _____ City: _____

Whom May We Thank For Referring You ? _____

Responsible Party Information

Father's Name: _____ Date of Birth: ____/____/____
Biological Father () Step-Father () Adoptive Parent () Guardian ()

Address/City/Zip (if different): _____

Employer/Position: _____

Soc. Sec. #: _____ Work Phone: _____ Home Phone: _____

Mother's Name: _____ Date of Birth: ____/____/____
Biological Mother () Step-Father () Adoptive Parent () Guardian ()

Address/City/Zip (if different): _____

Employer/Position: _____

Soc. Sec. #: _____ Work Phone: _____ Home Phone: _____

Who Is Accompanying This Child Today? () Mother () Father () Other

Relationship of Other: _____ Address: _____

Please List Brother's Ages: () () () () Sister's Ages: () () () ()

Other Family Members Seen By Us Prior to Today: _____

Medical History Of The Patient

Has The Patient Had Any Of The Following Medical Problems ?

Y	N	Allergic to Plastic	Y	N	Allergic to Latex/ Metals
Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/ Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding/ Hemophilia
Y	N	Hearing Impairment	Y	N	Kidney/ Liver Problems
Y	N	Rheumatic Fever	Y	N	HIV pos./ AIDS
Y	N	Asthma	Y	N	Hepatitis
Y	N	Tuberculosis	Y	N	Operations/ Hospital Stays
Y	N	Allergies to Medicines: _____			

Please list any unusual problems (or elaborate on the above) here: _____

Please list any medications the patient is currently taking: _____

Dental History Of The Patient

Has he/ she been evaluated by another orthodontist recently ?	Y	N
Has there been any other orthodontic treatment in the past ?	Y	N
Has there been any injury to the facial structures in the past ?	Y	N
Have the Tonsils or Adenoids been removed (circle) ?	Y	N
Has he/ she ever complained of jaw joint pain (TMJ/ TMD) ?	Y	N
Has the patient begun puberty (boys-voice, girls-menses) ?	Y	N

Does The Patient Have Any Of The Following Habits ?

Y	N	Thumb/ Finger Sucking	Y	N	Lip Sucking/ Biting
Y	N	Clenching/ Grinding Teeth	Y	N	Nail Biting
Y	N	Mouth Breathing	Y	N	Speech Problems

Attest

I understand that it is the office's policy to hold the accompanying parent or guardian responsible for a minor patient's account unless satisfactory arrangements are otherwise made in advance of the incurment of any charges. I further understand that the above information will be held in the strictest of confidence and agree to inform the office of any change in the health status of the patient.

I authorize the dental staff of Dr. Gregory A. Wadleigh, S.C. to perform the necessary dental procedures my child may require to adequately diagnose and plan treatment for his/her condition.

Signature of Parent/ Guardian

_____/_____/_____
Date