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Child Registration Form

Date: ______________________

Patient's Full Name: ____

Does the patient have a nickname? ____

Address: ____ City: _______________________ State: ______ Zip: _________

Phone: ________________________ Email Address: ____

Birth Date: __________________________ School: ____ Grade: _________

Whom should we thank for referring you to our office? ____

Name of patient's general Dentist: ____ Last Visit: ____________________

Has anyone in your family been treated in our office? ____

Sibling(s) & age(s): ____

Parent/Guardian	**Parent/Guardian**
Name: ____	Name: ____
Address: _______________________________________	Address: _______________________________________
Employer: ______________________________________	Employer: ______________________________________
Occupation: ____________________________________	Occupation: ____________________________________
Home Phone: ___________________________________	Home Phone: ___________________________________
Business Phone: ________________________________	Business Phone: ________________________________
Mobile Phone: __________________________________	Mobile Phone: __________________________________
Mobile Carrier :_________________________________	Mobile Carrier:_________________________________

Person responsible for the account: ____

Person responsible for making appointments: ____

Please circle how you would you like to receive appointment reminders: Email Text Message Both

Please help us to understand your child's dental condition and experiences by answering the following:

Has your child ever had:

Y N Abscessed or extracted teeth?

Y N Injured or chipped teeth?

Y N Any severe head injuries?

Y N Sore or bleeding gums?

Y N Limited opening of jaw?

Y N Numbness or tingling of the face?

Y N Previous orthodontic treatment? ___________________________________

Y N Bleeding that was hard to stop?

Has/Does your child:

Y N Suck fingers or thumb? Until what age: _____

Y N Breath predominately through their mouth?

Y N Clench or grind their teeth?

Y N Have missing permanent teeth?

Y N Have extra permanent teeth?

Y N Do any family members have a similar condition?

Y N Is your child ***allergic*** to Latex?

Y N Been hospitalized? If so, for what?____

Y N Is your child allergic to any drug or other substances? If so, what? ____

Please list all medications your child is currently taking: ____

Females: Has your child started menstruating? Yes No At what age? ______

Males: Has your child's voice changed? Yes No At what age? ______

Describe your child's current overall health: (circle one) Excellent Good Fair Poor

.

Please Circle All Conditions That Apply

Heart murmur	Hives/Rash	Hay fever/Allergies
Heart surgery	ADD/ADHD	Epilepsy
Rheumatic/Scarlet fever	Frequent headaches	Fainting
Heart pacemaker	Depression	Aids/HIV
Artificial heart valve	Thyroid disorder	Emotional problems/issues
Artificial joints	Sinus trouble	Diabetes
High/Low blood pressure	Hepatitis	Nervous/Anxious
Shortness of breath	Asthma	Immune system disorders
Chest pains	Tuberculosis	STD
Tactile defensive	Bronchitis	Autism

Has your child:

Expressed objections to wearing braces or headgear? **Y N**

Expressed anxiety about treatment? **Y N**

Been teased about the appearance of their teeth? **Y N**

Been interested in having their teeth straightened? **Y N**

Had an orthodontic evaluation before? **Y N** If yes, how long ago? _____________ Was treatment recommended? **Y N**

Has any member of your family experienced orthodontic treatment? **Y N** If yes, who? ____

Are you aware that some of your child's orthodontic appointments will infringe on school time? **Y N**

Who first noticed the need for orthodontic treatment? ____

What is your main reason for seeking an orthodontic evaluation today? ____

____

Is there any condition or other information that you think would be helpful for us to know about before we meet your child?

____

____

_____________________________________ _____________________________________

Parent or Guardian Signature Today's Date

Welcome Form

We would like to get to know you better.
Please give us some information
about yourself and the things that you like to do.

Your Full Name: ____

Do you have a Nickname? ____

What kind of music do you like and who are your favorite performers or groups? ______________

____

What kind of books or movies do you like? ____

____

Are you involved in sports, dance or other extracurricular activities? ______________________

____

Do you have any hobbies? ____

____

Do you play any musical instruments? ____

Is there a subject you like most in school? ____

What would you like to do when you finish school? ______________________________________

Do any of your friends come to our office? If so, who? ______________________________

____

Are you on facebook? Y N Please join us @ www.facebook.com/howardortho