CONFIDENTIAL

Dahlke Orthodontics

Patient Registration
For Patients Under Age 18

Date _____

PATIENT

Last Name_____, **First Name** _____ Middle Initial _____

Prefers To Be Called_____ Sex: ☐Male ☐Female Hobbies_____

Birth Date _____ /_____ /_____ Age_____ School _____ Grade_____

CUSTODIAL PARENT / GUARDIAN

Custodial Parent #1 _____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Relationship: ☐mother ☐father ☐stepmother ☐stepfather ☐grandparent(s) ☐Other_____

Contact Numbers: **Cell phone** (_____)_____-_____ Home phone (_____)_____-_____

Employer:_____ Work phone (_____)_____-_____

E-mail Address_____

Would you like to receive e-mails for announcements and appointment reminders from Dahlke Orthodontics? *(No solicitation)* ☐Yes ☐No

Physical Street Address_____

City_____ State_____ Zip code_____

Mailing Address (*if different from above*) _____

Custodial Parent #2 _____ ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Relationship: ☐mother ☐father ☐stepmother ☐stepfather ☐grandparent(s) ☐Other_____

Contact Numbers: **Cell Phone** (_____)_____-_____Home phone (_____)_____-_____

Employer:_____ Work phone (_____)_____-_____

E-mail Address_____

Would you like to receive e-mails for announcements and appointment reminders from Dahlke Orthodontics? *(No solicitation)* ☐Yes ☐No

Physical Street Address _____

City_____ State_____ Zip code_____

Mailing Address (*if different from above*) _____

DENTAL INSURANCE

Primary policy holder's full name_____ Birth Date _____ /_____ /_____

Social Security # _____-_____-_____ Relationship to patient _____

Employer_____ City, State_____

Insurance Company _____Group # _____ ID # _____

Insurance Co. Phone (_____)_____-_____ Insurance Co. City, State_____

Secondary policy holder's full name_____ Birth Date _____ /_____ /_____

Social Security # _____-_____-_____ Relationship to patient _____

Employer_____ City, State_____

Insurance Company _____Group # _____ ID # _____

Insurance Co. Phone (_____)_____-_____ Insurance Co. City, State_____

DENTIST

Patient's Dentist_____ City, State _____

Last date seen_____ Reason _____ Next appointment _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

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

Has any previous orthodontic treatment or consultations occurred? ☐ Yes ☐ No If yes, where? _____

Have any other family members been treated in our office? ☐ Yes ☐ No If yes, Name _____

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has your child had:

☐yes ☐no ☐dk/u Any injuries to face, head, neck?
☐yes ☐no ☐dk/u Arthritis or joint problems?
☐yes ☐no ☐dk/u Endocrine or thyroid problems?
☐yes ☐no ☐dk/u Diabetes or low sugar?
☐yes ☐no ☐dk/u Kidney problems?
☐yes ☐no ☐dk/u Immune system problems?
☐yes ☐no ☐dk/u History of osteoporosis?
☐yes ☐no ☐dk/u Sexually transmitted diseases?
☐yes ☐no ☐dk/u AIDS or HIV positive?
☐yes ☐no ☐dk/u Hepatitis, jaundice or other liver problems?
☐yes ☐no ☐dk/u Polio, mononucleosis, tuberculosis, pneumonia?
☐yes ☐no ☐dk/u Seizures, fainting spells, neurologic problem?
☐yes ☐no ☐dk/u Mental health disturbance or depression?
☐yes ☐no ☐dk/u History of eating disorder (anorexia, bulimia)?
☐yes ☐no ☐dk/u Frequent headaches or migraines?
☐yes ☐no ☐dk/u High or low blood pressure?
☐yes ☐no ☐dk/u Excessive bleeding or bruising tendency, anemia?
☐yes ☐no ☐dk/u Heart defects, heart murmur, rheumatic heart disease?
☐yes ☐no ☐dk/u Angina, arteriosclerosis, stroke or heart attack?
☐yes ☐no ☐dk/u Vision, hearing, or speech problems?
☐yes ☐no ☐dk/u Asthma, sinus problems, hay fever?
☐yes ☐no ☐dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐yes ☐no ☐dk/u Has your child ever taken intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate), Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders or cancer?

ALLERGIES

Has your child had allergies or reactions to any of the following?

☐yes ☐no ☐dk/u Latex (gloves, balloons)
☐yes ☐no ☐dk/u Local anesthetics (novocaine, lidocaine, xylocaine)
☐yes ☐no ☐dk/u Metals (jewelry, clothing snaps)
☐yes ☐no ☐dk/u Any Antibiotics (Penicillin)
☐yes ☐no ☐dk/u Plant pollens (environmental)
☐yes ☐no ☐dk/u Animals
☐yes ☐no ☐dk/u Foods
☐yes ☐no ☐dk/u Other substances _____

DENTAL HISTORY

Now or in the past, has the patient had:

☐yes ☐no ☐dk/u Erupting teeth very early or very late?
☐yes ☐no ☐dk/u Extra (supernumerary) teeth?
☐yes ☐no ☐dk/u Congenitally missing teeth?
☐yes ☐no ☐dk/u Chipped or injured teeth?
☐yes ☐no ☐dk/u Any missing or broken fillings?
☐yes ☐no ☐dk/u Jaw fractures, cysts, infections?
☐yes ☐no ☐dk/u Difficulty breathing through nose?
☐yes ☐no ☐dk/u Frequent oral habits (sucking finger, thumb, pacifier)?
☐yes ☐no ☐dk/u Clicking, locking in jaw joints?
☐yes ☐no ☐dk/u Tooth grinding or clenching?

American Association of Orthodontists
My Life. My Smile. My Orthodontist.™

PATIENT HEALTH INFORMATION

Please list any medication, nutritional or herbal supplements, non-prescription medicines, including fluoride that you take.

Medication _____ Taken for_____

Medication _____ Taken for_____

Any health concerns we should be aware of?_____

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

I authorize release of any information regarding my child's orthodontic treatment to my dental insurance company. As a condition of treatment by this office, I understand financial arrangements must be made in advance. I authorize and understand a complete examination to develop an orthodontic treatment plan sometimes includes x-rays, photographs, and study models. I have read the above conditions and agree to their content.

Parent/Guardian Signature _____ Date_____