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YOUTH PATIENT REGISTRATION

Date _____

Patient _____ Sex _____ Birthdate _____ Age _____

_____ First M.I. Last _____ City _____ State _____ Zip Code _____

Nickname _____ School: _____

Patient lives with: (Check all that apply) Mother Father Stepmother Stepfather Grandparent Other

Dental Insurance: Yes No Primary _____ Secondary _____

Parent 1 / Legal Guardian _____ Birthdate _____

_____ First M.I. Last _____

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Cell Phone (____) _____

Employer _____ Secondary Phone (____) _____

Employer Address _____ Email Address _____

Relationship to Patient: _____

Parent 2 / Legal Guardian _____ Birthdate _____

_____ First M.I. Last _____

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Cell Phone (____) _____

Employer _____ Secondary Phone (____) _____

Employer Address _____ Email Address _____

Relationship to Patient: _____

Patient's Dentist _____ City _____

Date of last dental exam _____ Date of last dental X-rays _____

Whom may we thank for referring you? _____

Why did you select our office? _____

Names of other family members previously seen at our office: _____

Brother / Sister name _____ age _____ had orthodontic treatment? Yes No

If yes, where? _____

Brother / Sister name _____ age _____ had orthodontic treatment? Yes No

If yes, where? _____

Brother / Sister name _____ age _____ had orthodontic treatment? Yes No

If yes, where? _____

(PLEASE COMPLETE BOTH SIDES)

SP-008



Patient Medical History

Patient's Physician _____ Clinic _____

Currently under a physician's care? _____ Reason _____

Have you been hospitalized in the last 5 years? _____ Reason _____

List all medications, nutritional supplements, herbal medicines, and/or non-prescription medications you are currently taking: _____

Do you chew or smoke tobacco? _____ If no, have you ever? _____ If so, when did you quit? _____

Do your parents or siblings have any unusual dental problems or jaw size imbalance? _____

What concerns you about your teeth/smile? _____

List all allergies including metal allergies: _____

Has the patient ever had:	YES	NO		YES	NO
Abnormal Blood Pressure (High _____ Low _____)	_____	_____	Heart Problems: (circle all that apply)	_____	_____
AIDS or HIV Positive	_____	_____	(heart attack, angina, coronary insufficient, arteriosclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)?	_____	_____
Birth Defects or Hereditary Problems?	_____	_____	Do you take Nitroglycerin? _____	_____	_____
Bone Fractures and/or Major Accidents	_____	_____	Hepatitis (Circle A, B, C)	_____	_____
Cancer, Tumor, Radiation or Chemotherapy?	_____	_____	Joint Replacement or Implant	_____	_____
Chemical Dependency (Drugs, Alcohol)	_____	_____	Mental Health Disturbance or Depression?	_____	_____
Diabetes: Diet Controlled	_____	_____	Polio, Mononucleosis, Tuberculosis, or Pneumonia?	_____	_____
Insulin Controlled	_____	_____	Rheumatic Fever	_____	_____
Eating Disorder History (anorexia, bulimia)?	_____	_____	Stomach Ulcers or Hyperacidity?	_____	_____
Endocrine or Thyroid Problems?	_____	_____	Asthma	_____	_____
Epilepsy	_____	_____	Women: Are you pregnant?	_____	_____
Excessive Bleeding or Bruising Tendency, Anemia, or other Bleeding Problem?	_____	_____	Are antibiotics required for dental work?	_____	_____
Glaucoma	_____	_____			

Have you ever taken **Fosamax, Zometa, Boniva, Actonel, Aredia** or any other medications for osteoporosis or bone cancer? _____

List other diseases, conditions or problems not listed above: _____

Describe any serious injury to your face, jaw or mouth: _____

Describe any problems with your jaw:

Clicking? _____

Pain (Joint, ear, side of face)? _____

Frequent headaches? _____

Difficulty in opening or closing? _____

Jaw ever locked or popped? _____

Clench or grind your teeth? _____

Have you ever had T.M.J. therapy? _____

I hereby authorize the release of any information relating to dental claims for benefits submitted on my behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Cambridge Pine City Orthodontics to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/ or dependents.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Cambridge Pine City Orthodontics.

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.

Signature: _____ **Date:** ____/____/____