

# Registration and History

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## Child Patient Information

Date \_\_\_\_\_

Patient \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Sex:  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

e-mail \_\_\_\_\_

### PARENTS

Father's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work# \_\_\_\_\_ Cell # \_\_\_\_\_

Mother's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work# \_\_\_\_\_ Cell # \_\_\_\_\_

Siblings (Ages) \_\_\_\_\_

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## Account/Insurance/Information

Who is responsible for the account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Is patient covered under Orthodontic insurance?  Yes  No

*\*If you have insurance, please supply us with a copy of your insurance card.*

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Sikora all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

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## Emergency Information

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home/Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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## Dental History

Dentist Name \_\_\_\_\_ Referred By \_\_\_\_\_

How many times per year does your dentist examine the patient's teeth \_\_\_\_\_

Approximate date of last visit \_\_\_\_\_

Is the patient concerned about the appearance of his/her teeth .....  Yes  No

Has the patient ever been teased about the appearance of his/her teeth .....  Yes  No

Does the patient play a musical instrument .....  Yes  No

If so, name \_\_\_\_\_

Has any other member of the family had orthodontic treatment .....  Yes  No

Are you aware that appointments will infringe upon school time .....  Yes  No

Has the patient ever received a severe blow to the teeth or jaws .....  Yes  No

Does the patient have any problems with sore gums .....  Yes  No

Does the patient brush his/her teeth in the morning, after lunch, at bedtime .....  Yes  No

Does the patient have any of the following habits: Thumb Sucking  Yes  No

Grinding teeth at night  Yes  No Mouth breathing  Yes  No

Has the patient had previous orthodontic treatment .....  Yes  No

Has the patient ever had speech therapy .....  Yes  No

Does the patient want his/her teeth straightened .....  Yes  No

Who first noticed the need for orthodontic treatment  Dentist  Parent  Patient

Please make any comments that you feel may be helpful \_\_\_\_\_

Over

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## Health History

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

- Is the patient currently under a physician's care .....  Yes  No
- Has the patient ever been hospitalized .....  Yes  No
- Is the patient receiving any medication .....  Yes  No
- Has the patient ever had surgery .....  Yes  No
- Are there any emotional problems .....  Yes  No
- Was the patient absent from school or work for more than 5 days last year  
due to illness .....  Yes  No
- Has the patient ever had an unusual reaction to any drug such as  
penicillin, local anesthetics, or antibiotics .....  Yes  No
- Does the patient have any other allergies (including reactions to jewelry or latex) .....  Yes  No
- Does the patient have damaged heart valves, artificial heart valves or  
congenital heart lesions, including heart murmur, or artificial joints .....  Yes  No
- Has the patient ever taken the appetite suppressant drugs fenfluramine (Pondimin) or  
dexphenfluramine (Redux) either alone or in combination with phentermine,  
commonly known as fen-phen .....  Yes  No
- Does the patient have any condition for which a physician or dentist has prescribed  
antibiotics to be taken prior to a dental procedure .....  Yes  No
- Does the patient have any physical limitations that affect motor coordination .....  Yes  No

\*\*If the answer to any of the above questions is YES, please explain:

\_\_\_\_\_

\_\_\_\_\_

If the patient has had any history or difficulty with any of the following, please check:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Chronic Sinus    | <input type="checkbox"/> HIV              |
| <input type="checkbox"/> Arthritis/Joint Inflammation | <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Immune Disorder  |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Kidney Disorder  |
| <input type="checkbox"/> Bladder Disorder             | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Liver Disorder   |
| <input type="checkbox"/> Blood Clotting Disorder      | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Malignancies     |
| <input type="checkbox"/> Cerebral Palsy               | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Heart Disorder   | <input type="checkbox"/> Thyroid Disorder |
|   |   | Other _____                               |

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## Updates (To be filled in at future appointments)

Has there been any change in your health since your last orthodontic appointment?  Yes  No

For what conditions: \_\_\_\_\_

Are you taking any new medications?  Yes  No If so, what \_\_\_\_\_

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Has there been any change in your health since your last orthodontic appointment?  Yes  No

For what conditions: \_\_\_\_\_

Are you taking any new medications?  Yes  No If so, what \_\_\_\_\_

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_