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ORTHODONTIC REGISTRATION CARD

DATE _____

DATE OF BIRTH _____

PATIENT'S NAME _____ Initial _____ Age _____ F/M
Last First

RES. ADDRESS _____ ZIP _____ TELEPHONE _____

CITY _____ IN CASE OF EMERGENCY CALL _____ TELEPHONE _____

SCHOOL _____ GRADE _____ REFERRED BY _____

PATIENT'S DENTIST _____ PHYSICIAN _____

PERSON RESPONSIBLE FOR ACCOUNT _____ OCCUPATION _____

BIRTH DATE _____ INSURANCE _____

EMPLOYED BY _____ BUS. TELEPHONE _____

SOCIAL SECURITY # _____

SPOUSE _____ OCCUPATION _____

BIRTH DATE _____ INSURANCE _____

EMPLOYED BY _____ BUS. TELEPHONE _____

SOCIAL SECURITY # _____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? _____ Yes ☐ No ☐

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ Yes ☐ No ☐

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? _____ Yes ☐ No ☐

PLEASE LIST: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

Diabetes ☐	Tuberculosis ☐	Endocrine Problems ☐
Pneumonia ☐	Anemia ☐	Prolonged Bleeding ☐
Heart Trouble ☐	Epilepsy ☐	Fainting or Dizziness ☐
Rhumatic Fever ☐	Asthma ☐	Nervous Disorders ☐
Bone Disorders ☐	Kidney Involvement ☐	Liver Involvement ☐

DOES PATIENT HAVE TENDENCY TO COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ Yes ☐ No ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

DO YOU HAVE ANY COMMUNICABLE DISEASES? Yes ☐ No ☐

IF YES, PLEASE EXPLAIN. _____

HEIGHT _____ WEIGHT _____

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ Yes ☐ No ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? _____ Yes ☐ No ☐

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? _____ Yes ☐ No ☐

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? _____ Yes ☐ No ☐

WHILE ASLEEP? _____ Yes ☐ No ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH _____ Yes ☐ No ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? _____ Yes ☐ No ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? _____ Yes ☐ No ☐

DOES THE PATIENT GRIND TEETH WHILE ASLEEP? Yes ☐ No ☐

REASON FOR CONSULTATION _____

TMJ POPPING OR CLICKING Yes ☐ No ☐ If yes, which side — Right ☐ Left ☐

TMJ PAIN Yes ☐ No ☐ If yes, which side — Right ☐ Left ☐

HEADACHES Yes ☐ No ☐

DOES PATIENT AWAKE WITH SORE JAW MUSCLES? Yes ☐ No ☐

HAS THERE BEEN A HISTORY OF TMJ PROBLEMS? Yes ☐ No ☐

_____
Parent or Adult Patient Signature