Date: ____/____/____

CHILD PATIENT REGISTRATION FORM

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Marcus Orthodontics
Specialist In Orthodontics

PATIENT INFORMATION

First | M.I. | Last | Nickname

Home Address Street | City | State | Zip

Home Telephone | Date of Birth/Age | Grade | School

☐ Boy
☐ Girl

Brothers / Ages | Sisters / Ages

PRIMARY PARENT ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First | M.I. | Last | SSN

Home Address (If Different) Street | City | State | Zip

Telephone Home | Cell | Office | Email Address

Employer | Business Address

Secondary PARENT ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First | M.I. | Last | SSN

Home Address (If Different) Street | City | State | Zip

Telephone Home | Cell | Office | Email Address

Employer | Business Address

In case of emergency, contact: | Telephone

Who may we thank for this referral?

BILLING

Who will pay for the account?
☐ Father ☐ Mother ☐ Other

Billing Name (If Different)

Billing Address Street | City | State | Zip

Do you have orthodontic insurance coverage? ☐ Yes ☐ No
If DUAL COVERAGE, make sure to complete both primary and secondary carrier sections.

INSURANCE

Primary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | Date of Birth

Secondary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | *Date of Birth*

PATIENT'S HEALTHCARE PROVIDERS

MEDICAL HISTORY

Physician's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Yes	No	
☐	☐	Has patient undergone a complete physical exam in the past year?
☐	☐	Is patient presently under a physician's care?
☐	☐	Has patient had major surgery?
☐	☐	Has patient ever been hospitalized?
☐	☐	Is patient taking any pills, drugs or medications? (List below under Additional comments)
☐	☐	Is patient allergic to any medication? (List below)
☐	☐	Has patient had any unusual reaction to a medication?
☐	☐	Has patient taken any diet medication (i.e., Fen-Fen)?
☐	☐	Has patient had tonsils and/or adenoids removed?
☐	☐	Does patient have fainting or dizzy spells?
☐	☐	Does patient have high or low blood pressure?
☐	☐	Has puberty begun?
☐	☐	For girls: Has menstruation begun?

List any musical instruments played: _____

Additional explanations or comments:

Check whether the patient has/had any of the following conditions:

☐ Heart Problems	☐ Diabetes
☐ Hepatitis	☐ Endocrine Problems
☐ Kidney Problems	☐ Bone Disorders
☐ Rheumatic Fever	☐ Arthritis
☐ Lung Problems	☐ Prolonged Bleeding
☐ Nervous Problems	☐ Anemia
☐ Liver Problems	☐ Asthma
☐ Psychiatric Care	☐ Tuberculosis
☐ Allergies	☐ Epilepsy
☐ Malignancies	☐ HIV+/AIDS

Is patient allergic or has reacted adversely to:

Yes	No	
☐	☐	Local anesthetics
☐	☐	Penicillin/other antibiotics
☐	☐	Sulfa drugs
☐	☐	Barbiturates, sedatives or sleeping pills
☐	☐	Aspirin
☐	☐	Codeine or other narcotics
☐	☐	Latex
☐		Other: _____

DENTAL HISTORY

Dentist's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Date of last dental exam: _____

What bothers the patient most about his/her teeth?

What do you and your child expect from orthodontic treatment?

Yes	No	
☐	☐	Has patient had previous orthodontic consultation or treatment?
☐	☐	Has patient been informed of any extra or missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Does patient suck his/her thumb or finger?
☐	☐	Does patient breathe predominantly through the mouth?
☐	☐	Does patient have any speech problems?
☐	☐	Does patient have pain or clicking in the jaw?
☐	☐	Has patient ever had pains in the face or head?
☐	☐	Have any teeth been injured or chipped due to an accident?
☐	☐	Has patient ever had a severe face or jaw injury?
☐	☐	Do patient's gums bleed on brushing or flossing?
☐	☐	Is patient concerned about appearance of his/her teeth?
☐	☐	Does patient want his/her teeth straightened?

ARE THERE ANY OTHER DENTAL / ORTHODONTIC PROBLEMS WE SHOULD BE AWARE OF?

Parent's Signature: _____ **Date:** _____

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