PATIENT REGISTRATION

Welcome to our office. This personal information will help us to be the most considerate of your time and feelings. The success of orthodontic care is a team effort between patients, parents, and we the providers. This information will help acquaint us with you or your child. It is important that you provide all the information requested. Thank you. All information is, of course, confidential.

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PATIENT INFORMATION

Patient Name _____ Nickname (if any) _____
Patient Address (Street)_____
(City)_____(State)____(Zip) _____Patient Phone Number_____
Patient Date of Birth_____ Patient Sex __Male __Female
Patient Cell Phone Number_____
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PARENT/GUARDIAN INFORMATION

Mother's Name _____ Mother's Home Phone No. _____
Mother's Employer _____ Mother's Work Phone No. _____
Mother's Cell Phone No. _____
Mother's Home Address (If different than patient's address)
(Street) _____ (City) _____ (State) _____ (Zip) _____

Father's Name _____ Father's Home Phone No. _____
Father's Employer _____ Father's Work Phone No. _____
Father's Cell Phone No. _____
Father's Home Address (If different than patient's address)
(Street) _____ (City) _____ (State) _____ (Zip) _____
Parents are __ married __ divorced __ separated
Step parents name(s) (if applicable) _____ _____
Patient lives with (check all that apply) __ mom __ dad __ joint custody __ other
Is there anything about your child's living situation, custody, guardianships, or other living arrangements of which we should be aware?_____
_____
Party responsible for payment _____
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Name and ages of children in the family_____
_____
Have any other family members had orthodontic treatment? Yes ___ No ___
Where was the orthodontic treatment rendered? _____
Whom may we thank for referring you to our office? _____
Relationship _____ Address _____
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HABITS

	NOW	PAST		NOW	PAST
Thumb sucking	___	___	Smoking	___	___
Nail biting	___	___	Grinding	___	___
Tongue thrust	___	___	Mouthbreathing	___	___
Pacifier	___	___	Other (explain)	_____	

DENTAL HISTORY

Patient's Dentist_____
When seen last? _____
Has patient ever had any problem following dental care? _____
Has the patient ever experienced trauma to his/her teeth, lips, or jaw?_____

MEDICAL HISTORY

Physician's name _____
List any handicaps/disabilities of which we should be aware? _____
Does patient respond to instructions, given age level ? _____
Does patient have many _____ colds _____ ear infections ____ sore throats ?
(Estimated No. per year) _____
Any medication ? If so, list names and dosage _____
_____
Any broken bones ? _____ Problems healing? _____
Have tonsils and / or adenoids been removed ? _____ Age _____

Has patient reached puberty? Girls, started menstruation ___ yes ___ no
Boys, voice change ___ yes ___ no
Any speech problems? _____
Any difficulty chewing? _____ Swallowing? _____ Yawning? _____
Any joint sounds, popping or clicking ? _____
Any pain in or about the jaw joints, ears, or cheeks ? _____
Any injury to jaws, neck or head ? _____
Any hospitalization ? (Explain) _____

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PLEASE CHECK ANY OF THE FOLLOWING THAT YOUR CHILD HAS OR HAS HAD IN THE PAST.
IF YOU ARE AN ADULT PATIENT, PLEASE LIST ANY PERTINENT MEDICAL HISTORY YOU HAVE HAD.

___ Heart Murmur
___ Anemia
___ Diabetes
___ Arthritis
___ Bone Disorder
___ Stroke
___ Sinus Problems
___ Nervous Disorder
___ Rheumatic Fever
___ Prolapsed Mitral Valve
___ Bleeding Disorder
___ Gout
___ Allergies
___ Heart Trouble
___ Blood Transfusions
___ Faint/Dizziness
___ Cancer
___ Kidney Problems
___ Low Blood Pressure
___ High Blood Pressure
___ Epilepsy
___ Asthma
___ Hay Fever
___ Tuberculosis
___ HIV/Aids
___ Hepatitis
___ Endocrine Problems

PLEASE SIGN IN BOTH BOXES BELOW AND BRING THIS FORM WITH YOU TO YOUR 1ST VISIT.

I have reviewed the above medical history and will alert you to any future changes in my/my child's health status if and when they arise.

_____ _____ _____
Signature Relationship to patient Date

I hereby consent to examination, consultation and if indicated, the making of diagnostic records, including x-rays to be used by the orthodontist in determining what treatment needs my son/daughter/self may have by Dr. Heather Braun Buccieri and/or her associates.

_____ _____ _____
Signature Relationship to Patient Date