LEE, YOUNG & UBALDO ORTHODONTICS / CHILD REGISTRATION

Thank you for completing the information below. All information will be kept confidential and will help us provide the best care and service.

DATE

PATIENT NAME: FIRST M. LAST PREFERRED NAME

HOME ADDRESS: STREET CITY STATE ZIP

HOME PHONE: AGE BIRTHDAY (MONTH/DAY/YEAR) ☐ BOY ☐ GIRL

HOW WOULD YOU LIKE US TO CONTACT YOU? ☐ PHONE ☐ EMAIL ☐ BOTH

HOW WOULD YOU LIKE TO RECEIVE REMINDERS FOR YOUR APPOINTMENTS? ☐ PHONE ☐ TEXT ☐ EMAIL ☐ ALL

GRADE SCHOOL BROTHERS/AGES SISTERS/AGES

1. GUARDIAN NAME: ☐ MR. ☐ MRS. ☐ DR. ☐ MS. FIRST M. LAST RELATIONSHIP TO CHILD

GUARDIAN ADDRESS (IF DIFFERENT): STREET CITY STATE ZIP

GUARDIAN PHONE: HOME CELL OFFICE/EXT. EMAIL ADDRESS

GUARDIAN EMPLOYER: BUSINESS ADDRESS

2. GUARDIAN NAME: ☐ MR. ☐ MRS. ☐ DR. ☐ MS. FIRST M. LAST RELATIONSHIP TO CHILD

GUARDIAN ADDRESS (IF DIFFERENT): STREET CITY STATE ZIP

GUARDIAN PHONE: HOME CELL OFFICE/EXT. EMAIL ADDRESS

GUARDIAN EMPLOYER: BUSINESS ADDRESS

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? ☑ GUARDIAN 1 ☐ GUARDIAN 2 ☐ OTHER

BILLING ADDRESS (IF DIFFERENT)

DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE? ☐ YES ☑ NO

IF YES PLEASE COMPLETE INSURANCE INFORMATION FORM

WHOM MAY WE THANK FOR REFERRING YOU?

ARE WE TREATING ANY OF YOUR FRIENDS / FAMILY MEMBER? ☑ YES ☐ NO IF YES, NAME? _____

MEDICAL HISTORY

PHYSICIAN'S NAME DATE OF LAST VISIT

ADDRESS STREET PHONE

CITY STATE ZIP

DENTAL HISTORY

DENTIST'S NAME DATE OF LAST VISIT

ADDRESS STREET PHONE

CITY STATE ZIP

YES NO

- ☐ ☐ HAS PATIENT UNDERGONE A 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, MEDICATIONS OR DRUGS?
- ☐ ☐ IS PATIENT ALLERGIC TO ANY MEDICATION?
- ☐ ☐ HAS PATIENT HAD ANY UNUSUAL REACTION TO ANY MEDICATION?
- ☐ ☐ HAS PATIENT TAKEN BISPHOSPHONATES? (IE: FOSAMAX, ACTONEL, OR ZOMETA)
- ☐ ☐ HAS PATIENT TAKEN ANY DIET MEDICATION (IE: 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 PATIENT BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING?

☐ HEART PROBLEMS	☐ HEPATITIS
☐ KIDNEY PROBLEMS	☐ RHEUMATIC FEVER
☐ LUNG PROBLEMS	☐ EMOTIONAL PROBLEMS
☐ LIVER PROBLEMS	☐ MALIGNANCIES
☐ ALLERGIES	☐ ENDOCRINE PROBLEMS
☐ DIABETES	☐ BONE DISORDERS
☐ EPILEPSY	☐ PROLONGED BLEEDING
☐ ANEMIA	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ ASTHMA

☐ ☐ ARE THERE ANY OTHER MEDICAL PROBLEMS WE SHOULD BE AWARE OF?

_____

_____

WHAT BOTHERS THE PATIENT MOST ABOUT HIS/HER TEETH? _____

_____

_____

WHAT DO YOU AND THE PATIENT 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?
- ☐ ☐ HAS ANY FAMILY MEMBER HAD ORTHODONTIC TREATMENT? WHO? _____
- ☐ ☐ DOES PATIENT NOW SUCK THEIR THUMB OR FINGER?
- ☐ ☐ DOES PATIENT BREATHE PREDOMINANTLY THROUGH THE MOUTH?
- ☐ ☐ DOES PATIENT HAVE ANY SPEECH PROBLEMS?
- ☐ ☐ DOES PATIENT GRIND OR CLENCH THEIR TEETH?
- ☐ ☐ DOES PATIENT HAVE PAIN OR CLICKING OF THE JAW JOINT?
- ☐ ☐ HAVE ANY TEETH BEEN INJURED OR CHIPPED DUE TO AN ACCIDENT?
- ☐ ☐ HAS PATIENT EVER HAD PAINS IN THE FACE OR HEAD?
- ☐ ☐ HAS PATIENT EVER HAD A SEVERE JAW OR HEAD INJURY?
- ☐ ☐ DO PATIENT'S GUMS BLEED ON BRUSHING OR FLOSSING?
- ☐ ☐ IS PATIENT CONCERNED ABOUT APPEARANCE OF THEIR TEETH?
- ☐ ☐ DOES PATIENT WANT THEIR TEETH STRAIGHTENED?
- ☐ ☐ ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS WE SHOULD BE AWARE OF? _____

_____

GUARDIAN SIGNATURE: _____ DATE: _____