Faust Orthodontics
Helping you live life smiling!

FAUST ORTHODONTICS
PATIENT REGISTRATION AND HEALTH/DENTAL HISTORY - CHILD

Welcome to our office. Please fill out both pages of this form. All information is CONFIDENTIAL.

Patient Information

Patient's Name:_____ Birth Date:_____ Age_____ Sex: ☐ F ☐ M

Prefers to be called: _____ School:_____ Grade:_____

Address:_____ City: _____ State:_____ Zip: _____

Home Phone #:_____ Hobbies, Sports, Instruments:_____

Whom may we thank for referring you: _____

Other family members who are patients of our office:_____

Other Children in the Family *(List Name(s) and Date of Birth):*

Parent/Guardian Information

Father's Name: _____ Title: ☐ Mr. ☐ Dr. ☐ Other_____

Occupation and employer:_____ Email address: _____

Cell #:_____ Work #:_____ Home # *(if different)*: _____

Home Address *(if different)*: _____

Mother's Name:_____ Title: ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other_____

Occupation and employer:_____ Email address: _____

Cell #:_____ Work #:_____ Home # *(if different)*: _____

Home Address *(if different)*: _____

Parents' Marital Status: ☐ Married ☐ Divorced (custodial parent(s)_____ ☐ Separated ☐ Single ☐ Widowed

Patient lives with *(check all)*: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparents ☐ Other_____

Guardian's Name: _____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other_____

Occupation and employer:_____ Email address: _____

Cell #:_____ Work #:_____ Home # *(if different)*: _____

Home Address *(if different)*: _____

Responsible for the account: ☐ Father ☐ Mother ☐ Guardian ☐ Other

Emergency Contact (name and phone number)**:**

Dental Insurance

Primary Insurance Co:_____ Group #:_____ Ortho Coverage: ☐ Y ☐ N

Insured's Name:_____ SS #: _____ DOB:_____

Secondary Insurance Co: _____ Group #:_____ Ortho Coverage: ☐ Y ☐ N

Insured's Name:_____ SS #: _____ DOB:_____

Other:

Patient's Dentist: _____ Last Dental Exam/Cleaning Date: _____

Parents/Patient's main orthodontic concern? _____

How does the patient feel about having orthodontic treatment? _____

What aspect(s) of orthodontic treatment are you most concerned with? ☐ Quality ☐ Cost ☐ Time ☐ Discomfort

☐ Have you had a previous orthodontic consult? Date: _____ Orthodontist's name: _____

☐ Other family members have had orthodontic treatment? Satisfied with the results? ☐ Y ☐ N

☐ Father (Dr. _____) ☐ Mother (Dr. _____) ☐ Brother (Dr. _____) ☐ Sister (Dr. _____)

☐ Antibiotic premedication is needed before dental procedures? Antibiotic and dosage taken: _____

☐ Oral Habits (thumb/finger sucking, lip/nail biting)? **Explain:** _____

☐ Problems with Teeth or Gums? ☐ Speech Problems/Therapy? ☐ Difficulty Opening Jaw?

☐ Grind or Clench Teeth? ☐ Pain, Tenderness in Jaw? ☐ Mouth Breathing or Snoring?

☐ Any Missing or Extra Permanent Teeth? ☐ Popping, Noises in Jaw? ☐ Tongue Thrusting or Functional Problems?

☐ Injury to Face, Teeth, or Mouth? Explain: _____ Other Dental Info: _____

Medical Information

Name of Family Physician: _____ Last Physical Exam: _____ Weight: _____ Height: _____

Any Hospitalizations or Surgeries? **Explain:** _____

Under the care of a physician for an illness? **Explain:** _____

Current Medications (including non-prescription), supplements, or herbs? ***List all and reason for taking:*** _____

_____

_____

Check the boxes if your child has or ever had any of the following:

☐ **Patient has started puberty** (girls: menstruating or boys: voice change) Approx when? _____ ☐ Showing signs of recent growth?

Have Allergies: ☐ Local Anesthetic ☐ Aspirin ☐ Ibuprofen ☐ Penicillin/Amoxicillin ☐ Sulfa Drugs ☐ Codeine ☐ Metal ☐ Latex ☐ Food (specify) _____ ☐ Other (specify) _____

☐ ADD/ADHD	☐ Bone Disorders/Bone Loss	☐ Heart Disease/Heart Attack/Stroke	☐ Stomach/Bowel Problems
☐ Autism	☐ Cancer/Chemotherapy/Radiation	☐ Chew or Smoke Tobacco	☐ Low Blood Pressure/Fainting
☐ Autoimmune Disorders	☐ Diabetes/Endocrine Problems	☐ High Blood Pressure	☐ Substance Abuse
☐ Artificial Valves or Joints	☐ Eating Disorder	☐ Headaches/Migranes	☐ Rheumatic Fever/Endocarditis
☐ Arthritis	☐ Emotional Problems/Depression	☐ Herpes (Cold Sores)	☐ Tonsils/Adenoids Removed
☐ Asthma/Breathing Difficulties	☐ Epilepsy/Seizures	☐ Hepatitis/Liver Problems	☐ Thyroid Problems
☐ Birth/Congentical Defects	☐ Handicaps/Disabilities	☐ HIV/AIDS Positive	☐ Tuberculosis
☐ Blood/Bleeding Disorders	☐ Heart Defect/Murmur/Valve Prolapse	☐ Kidney Disease	☐ STDs

☐ Taken bisphosphonates such as Zometa, Aredia, Didorenal, Fosamax, Actonel, Boniva, Skelid or Didronel, etc. for bone disorders, osteoporosis or cancer?

Other medical information (attach additional sheets if necessary):

I certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE OR UNDISCLOSED INFORMATION. I understand that it is my responsibility to inform this office of any changes to the patient's medical/dental status. I grant authority to the doctor and staff to perform all procedures and treatment in the patient's best interest. I authorize the orthodontist to share pertinent treatment information with collaborating dentists and specialists. I authorize the billing of insurance for treatment procedures when appppropriate.

_____ _____ _____ _____

Signature of Parent Guardian **Date** **Signature of Orthodontist** **Date**