WELCOME TO OUR PRACTICE!

CHILD REGISTRATION AND HEALTH HISTORY   Today's Date ____________________

PATIENT INFORMATION   Birth Date ____________________ Age _________

Child's First Name ________________________ Last Name ___________________________ Nickname ____________________

Child's Address _____________________________________ City ______________________ State _______ Zipcode __________

Home Phone _______________________ School _________________________ Grade ____ Sports/Hobbies__________________

Father's Full Name ______________________________________ Mother's Full Name ____________________________________

Father's Employer ___________________________________ Work Phone __________________ Cell Phone __________________

Mother's Employer __________________________________ Work Phone __________________ Cell Phone __________________

Parent's Marital Status (please circle): Single Married Partners Divorced Separated Widowed

Person Responsible for this Account ____ Relationship to Child ___________________

Responsible Party Address __________________________________ City ______________________ State _____ Zipcode________

Parent(s) Email Address ____

Whom may we thank for referring you? ____

In case of emergency, who should we contact? ____ Phone ____________________

Please describe your orthodontic concerns ____

PRIMARY DENTAL INSURANCE (if applicable)

Policy Holder's Full Name _______________________________ Birth Date_______________ SSN _________________________

Insurance Company ________________________________ Subscriber ID # ____________________ Group # _________________

SECONDARY DENTAL INSURANCE (if applicable)

Policy Holder's Full Name _______________________________ Birth Date_______________ SSN _________________________

Insurance Company ________________________________ Subscriber ID # ____________________ Group # _________________

DENTAL HISTORY

Name and Address of Family Dentist ____ Date of Last Visit _____________

Does your child have unfinished work that needs to be finished by your child's dentist? …. If yes, describe______________________
Does your child need to be premedicated for dental visits? ……………………………….. If yes, describe______________________
Have baby teeth or permanent teeth been removed? ……………………………………… If yes, describe______________________
Has your child been seen by an orthodontist previously? …………………………………. If yes, describe______________________
Does your child have or ever had any of the following: (Please Circle)

Bleeding/Sore Gums	Difficulty Opening/Closing Jaw	Missing teeth/Extra teeth
Unpleasant Taste/Bad Breath	Clicking/Popping Jaw Joint	Injury to mouth, teeth, or head
Frequent Blisters (mouth/lips)	Food Impaction	Previous orthodontic treatment/Braces
Biting Cheek/Lips	Sensitive to Hot/Cold/Sweets	Clenching/Grinding (if so, when________)
Burning Tongue	Nail Biting/Thumb or Finger Sucking	Dry Mouth/Mouth Breather
Mouth/Jaw Pain	Periodontal (Gum) Treatment	Headaches (more than normal)
Jaw Joint Soreness	Speech Problems	Other ______________________________

Please Complete Other Side

MEDICAL HISTORY

Name and Address of Child's Physician ____ Phone ________________

Is your child currently under any medical treatment? ………………………. If yes, describe ________________________________
Has your child ever had surgery or been hospitalized? ……………………… If yes, describe ________________________________
Is your child currently taking any medications? ……………………………. If yes, describe ________________________________
Is your child allergic to Penicillin or other medications, foods, latex, etc.? .... If yes, describe ________________________________
Does your child have or ever had a history with any of the following: (Please Circle)

AIDS/HIV	Blood Disease	Epilepsy	Kidney Problems	Rheumatic Fever
Anemia	Cancer	Fainting	Latex Allergy	Stroke
Arthritis	Cerebral Palsy	Glaucoma	Liver Problems	Sinus Problems
Artificial Joints	Chicken Pox	Heart Defects	Mumps	Smoking
Asthma	Convulsions	Heart Murmur	Migraines/Headaches	Tonsillectomy
Allergies/Hay fever	Chemical Dependency	Hearing Issues	Measles	Tuberculosis
Bladder Problems	Diabetes	Hernia	Mononucleosis	Thyroid Conditions
Bleeding Tendency	Emotional Problems	Hepatitis (Type___)	Pacemaker	Ulcers
Behavior Problems	Emphysema	High Blood Pressure	Pneumonia	

Other ____

ASSIGNMENT and CONSENT

I hereby authorize payment directly to Dr. M. Marie Dang for all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance company, and for all services rendered on my behalf and/or my dependents. I authorize the Doctor and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and understand the above history questionnaire. If there are subsequent changes to this history record or medical/dental status, I will inform this practice. I also authorize the Doctor to perform the necessary diagnostic procedures to make a thorough diagnosis of the patients' dental and oral-facial needs, including x-rays, study models, and photographs.

Signature of Responsible Party ____ Date ______________________

Signature of Doctor ____ Date ______________________

MEDICAL//DENTAL UPDATES **(To be completed at future appointments)**

Are there any changes in your child's health? If yes, please describe ____

Is your child taking any new medications? If yes, please describe ____

Is there a change in your child's dentist or physician? If yes, please describe ____

Signature of Responsible Party ____ Date __________________________

Signature of Doctor ____ Date __________________________

Are there any changes in your child's health? If yes, please describe ____

Is your child taking any new medications? If yes, please describe ____

Is there a change in your child's dentist or physician? If yes, please describe ____

Signature of Responsible Party ____ Date __________________________

Signature of Doctor ____ Date __________________________