



Grubaugh 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				PAGE 1 of 2	
Patient's Name: _____		Birth Date: _____	Age: _____	Sex: F	M
Patient 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 Grandparent(s) 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 numbers):					
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 is the *parent* most concerned with? Quality Cost Time Discomfort

Patient had a previous orthodontic consult? Date: _____ Orthodontist 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 Problem?
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?

Has Allergies: Local Anesthetic Food(specify) _____ Aspirin Ibuprofen Penicillin/Amoxicillin Other (specify) _____ Sulfa drugs Codeine Metal Latex

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/Migraines	Rheumatic Fever/Endocarditis
Arthritis	Emotional Problems/Depression	Herpes (Cold Sores)	Tonsils/Adenoids Removed
Asthma/Breathing Difficulties	Epilepsy/Seizures	Hepatitis/Liver Problems	Thyroid Problems
Birth/Congenital 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 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 appropriate.

Signature of Parent or Guardian

Date

Signature of Orthodontist

Date