Patient's Preferred Name_____DOB_____Age_____

Parents' Name(s)_____

ORTHODONTIC HISTORY

Have you consulted an orthodontist previously? **No** ☐ **Yes** ☐
Have you had prior orthodontic treatment? **No** ☐ **Yes** ☐
What motivated you to seek orthodontic care? _____
What are your expectations from orthodontic treatment? _____
_____
How do you feel about wearing braces? _____

Have any of your friends or members of your family received orthodontic services at our office? **Y** **N**

Name	Relationship	Name	Relationship

MEDICAL HISTORY

Physician's Name _____
Are you in good health? Y/ N

Check any of the following for which you are now being or have been treated:

a. Rheumatic fever ☐
b. Congenital heart problems ☐
c. Heart murmurs or heart surgeries ☐
d. Artificial joints ☐
e. Any condition that requires prophylaxis (antibiotics) before dental procedures ☐
f. Cardiovascular disease (heart trouble, heart attack, high blood pressure, stroke) ☐
g. Hepatitis ☐
h. Hemophilia ☐
i. Diabetes ☐
j. Epilepsy / Convulsions ☐
k. Asthma ☐
l. AIDS or HIV positive ☐
m. Tuberculosis ☐

*For Males: has your voice changed? **Y / N**
*For Females: has menstruation started? **Y / N**
List any other serious recurrent illness (physical or mental) _____

Prescription medications being taken _____

Drug allergies/sensitivity_____

Does patient have a Latex Allergy/Sensitivity? **Y / N**
Is patient allergic/intolerant to metals? **Y / N** If yes explain_____

DENTAL HISTORY

Patient's Dentist _____
Date of last check-up and cleaning _____

Check if you have had any of the following treatment:

1. Periodontal treatment (gum treatment) ☐
   How long ago _____
   Describe the treatment _____
2. Mouthguard or bite splint ☐
3. Surgery to change the bite ☐

Are you aware of any of the following conditions?

1. Sores, lumps or irritated areas in mouth ☐
2. Food catching between teeth ☐
3. Clenching or grinding of teeth ☐
4. Sore or bleeding gums ☐
5. Clicking, popping or grating noise in jaw joint ☐
6. Numbness or tingling in mouth or face ☐
7. Thumb Sucking ☐
8. Mouth Breather ☐

Has Patient had tonsils/adenoids removed? **Y / N**
Has patient had an unpleasant experience at a dental office?
If yes explain:_____

The information I have given is correct and will be held in the strictest of confidence.

Signature of Guardian _____**Date** _____

Updated_____	_____	_____	_____
Initials/Date	**Initials/Date**	**Initials/Date**	**Initials/Date**

Welcome to our office!

Eagle River Orthodontics
16635 Centerfield Dr, Suite 201

CHILD REGISTRATION FORM

(Please Print)

Today's date: | General Dentist

Whom may we thank for referring you to our office?

PATIENT INFORMATION

Last Name: | First: | Middle: | Sex: M F

Preferred Name: | SSN: | Birth Date: | Email:

School: | Grade: | Hobbies:

LEGAL GUARDIAN(S) INFORMATION (CUSTODIAL PARENT RESPONSIBLE FOR ACCOUNT)

Last Name: | First Name: | Middle: | Birth Date:

SSN: | Drivers License #: | Work Phone: | Cell Phone:

Employer: | Occupation: | Email:

Last Name: | First Name: | Middle: | Birth Date:

SSN: | Drivers License #: | Work Phone: | Cell Phone:

Employer: | Occupation: | Email:

Mailing Address: | City: | State: | Zip:

Physical Address: | City: | State: | Zip:

Home Phone:

NON-CUSTODIAL PARENT

Last Name: | First Name: | Middle: | Birth Date:

SSN: | Drivers License #: | Work Phone: | Cell Phone:

Employer: | Occupation: | Email:

Mailing Address: | City: | State: | Zip:

Physical Address: | City: | State: | Zip:

Home Phone:

ORTHODONTIC INSURANCE INFORMATION

Policy Holder Name: | Employer of Policy Holder:

Primary Insurance Company:

Insurance Company Address:

City: | State: | Zip: | Phone:

Insurance ID: | Group #: | Policy #:

Policy Holder Name:

Secondary Insurance Company | Employer of Policy Holder:

Insurance Company Address:

City: | State: | Zip: | Phone:

Insurance ID: | Group #: | Policy #:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (Not Living at Same Address)

Relationship: | Contact #:

I hereby authorize the release of any information to my insurance company or companies including records of examinations, diagnosis, or treatment. This release is solely for the purpose or facilitating the billing and reimbursement, directly to Eagle River Orthodontics, of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered.

Date:_____Responsible Party Signature:_____