# HUB CITY ORTHODONTICS

## PATIENT REGISTRATION (PLEASE PRINT)

PATIENT

Patient's Last Name: ________________________ First Name: ______________________ Middle Name/Initial: ______

Birth Date: ___/___/____ Age: ______ Identifies as Male/Female/_______ Prefers to be Called: _____________

Home Phone No.: (_____) _____-_____________ Cell phone: (____) ____-_______

Address: ______________________________________ City: _______________________ State: _____ Zip: __________

Number of Siblings: ________________ Other Family Members Treated Here: ___________________________

Who Referred You To Our Office? Dentist / Friend ____________/ Family ____________ / Internet / Other _________

Attends School @ ______________________________ Grade: _____ Hobbies: ______________________________

PARENT/GUARDIAN

**Custodial Parent or Guardian #1**: ______________________________ Relationship to Patient: _________________

Home Phone No. (if different than patient's): (____) ____-_______ Cell phone: (____) ____-_______

Address (if different than patient's): ______________________________ City: ________________ State: ____ Zip: ____

Employer ______________________________________ Length of Employment: _________________________

Business phone: ______________________ Email address: __________________________

**Custodial Parent or Guardian #2**: ______________________________ Relationship to Patient: __________________

Home Phone No. (if different than patient's): (____) ____-_______ Cell phone: (____) ____-_______

Address (if different than patient's): ______________________________ City: ________________ State: ____ Zip: ____

Employer ______________________________________ Length of Employment: _________________________

Business phone: ______________________ Email address: __________________________

**Marital Status of Guardians (circle one):** Married / Single / Separated / Widowed / Divorced

DENTIST/PHYSICIAN

**Name Of Patient's Dentist**: ____________________________ City: _______________ Phone No.: (___ ) ____-_____

Date Last Seen: ______________ Reason: _______________________

**Name Of Patient's Physician**: __________________________ City: _______________ Phone No.: (___ ) ____-_____

FINANCIAL

**Who Is Financially Responsible For This Account**? _________________________ Relationship to Patient: __________

Insurance Coverage For Orthodontic Treatment? Yes No Unsure

**Primary Policy Holder's Name**: _________________________________________________

Dental Insurance Company: __________________________ Group # ________________ Subscriber ID: _____________

**Secondary Policy Holder's Name**: _________________________________________________

Dental Insurance Company: __________________________ Group # ________________ Subscriber ID: _____________

For the following questions mark YES or NO. The answers are for office records only and will be consider confidential.

**PATIENT PROFILE**

Yes No Does the patient brush his/her teeth conscientiously?
How often does the patient brush? _______________
Yes No Are there any learning concerns or need for extra help with instructions?
Yes No Is the patient self-conscious about his/her teeth?
If yes, explain: _______________________________

**MEDICAL HISTORY (PAST OR PRESENT)**

Yes No Birth defects or hereditary diagnoses
Yes No Bone fractures, any major incidents
Yes No Endocrine or thyroid diagnoses
Yes No Diabetes
Yes No Autism Spectrum Disorder
Yes No Cancer, tumor, radiation, or chemotherapy
Yes No Stomach ulcer or hyperacidity
Yes No Polio, mononucleosis, tuberculosis, or pneumonia
Yes No Skin Disorder
Yes No Fainting, seizures, epilepsy, neurologic problems
Yes No AIDS or HIV positive
Yes No Hepatitis, jaundice, or liver problem
Yes No Problems of the immune system
Yes No Mental health or behavioral concerns
Yes No Vision, hearing, tasting or speech difficulties
Yes No Loss of weight recently, poor appetite
Yes No History of eating disorder (anorexia, bulimia)
Yes No Excessive bleeding or bruising tendency, anemia, or bleeding disorder
Yes No High or low blood pressure
Yes No Rheumatic fever
Yes No Chest pain, shortness of breath or swelling ankles
Yes No Hemophilia
Yes No Heart Murmur
Yes No Breathing difficulty
Yes No Hayfever, asthma, sinus trouble or hives
Yes No Frequent headaches, colds, or sore throats
Yes No Eye, ear, nose or throat condition

**MEDICATIONS**

Yes No Does the patient require premedication?
Yes No Is the patient currently taking any medications?
If yes, please list: ________________________________
_______________________________________________

**ALLERGIES**

Yes No Dental material
Yes No Local Anesthetics
Yes No Latex
Yes No Vinyl/Acrylic
Yes No Medications
If yes list: _______________________

**OPERATIONS/HOSPITALIZATIONS**

Yes No Tonsils removed
Yes No Adenoids removed
Yes No Blood transfusions
Yes No Joint replacement/prosthetic implant

**GROWTH AND DEVELOPMENT**

Yes No Abnormal growth pattern
Yes No Recent rapid growth
Yes No Any signs of puberty

**FEMALE PATIENTS ONLY**

Yes No Started menstruation
If yes, approximate date: _________
Yes No Pregnant

**DENTAL HISTORY (PAST OR PRESENT)**

Yes No History of dental trauma
Yes No Jaw fractures or cysts
Yes No Bleeding gums
Yes No Tooth grinding/clenching
Yes No Joint noises (clicking/pop)
Yes No Jaw/face pain
Yes No Sensitive teeth
Yes No Thumb/finger/sucking habit
If yes, until what age? _________
Yes No Chewing difficulties
Yes No Congenitally missing adult teeth
Yes No Previous orthodontic treatment

**OTHER HEALTHCARE PROFESSIONAL**

Yes No Are you currently under the care of another healthcare professional?
Name of Doctor: __________________
Reason: _________________________

**If someone other than a parent or legal guardian consistently brings the patient to our office for appointments, do we have your permission to share any information, including financial with them?** Yes No
**If yes, please specify:** ______________________________________________________________

**I have read and understand the above questions. I will not hold my orthodontist or any member of his/her team responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will notify Hub City Orthodontics.**

Guardian Name (print): _________________________________________ Date: ______________________________

Guardian Name (signature): _______________________________________

Doctor (signature): ____________________________________________ Date: ______________________________