HUB CITY ORTHODONTICS

PATIENT REGISTRATION (PLEASE PRINT) **Date:_____**

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: _____