

MONTICELLO FAMILY DENTISTRY
CHILD ORTHODONTIC REGISTRATION FORM

Date: _____

Patient's Name _____ Sex _____ Birthdate _____

Home Address _____

Home Phone _____ Father's Cell _____ Mother's Cell _____

Father's Name _____ Mother's Name _____

Father's Employer _____ Mother's Employer _____

Father's Social Security # _____ Mother's Social Security # _____

Person Responsible for Account _____

Do you have orthodontic insurance? YES NO If Yes, name & address of insurance company:

_____ Maximum _____ Ded. _____

Family Dentist: _____ Family Physician _____ Referred by: _____

Patient's Ht. _____ Wt. _____ Father's Ht. _____ Mother's Ht. _____

Does father have normal teeth? _____ Treated orthodontically? _____

Does mother have normal teeth? _____ Treated orthodontically? _____

Does brother or sister have orthodontic problem? _____ Treated? _____

Names of family members who are or were patients in our office: _____

Any injuries or operations involving head or face? _____

Are you taking any medications? YES NO If Yes, what? _____

Any difficulty chewing or swallowing? _____ Breathing through nose? _____

Any pain or noise when opening or closing mouth? _____

Does patient have or have had any of the following:

Allergies _____	Asthma _____	Nasal/Sinus Difficulty _____
Blood Disorder _____	Tonsilitis _____	AIDS/HIV _____
Heart Murmurs _____	Hepatitis (HBV) _____	Rheumatic Fever _____

Any other medical problems? _____

Any oral habits: Thumb Sucking _____ Mouth Breathing _____

Reason for orthodontic treatment: _____