EDWARDS ORTHODONTICS

NEW PATIENT REGISTRATION
FOR OUR PATIENTS 18 AND UNDER

Last Name_____ First Name_____ Middle Initial____ Preferred Name_____
Date of Birth_____ Age_____ Gender: M__ F__ Sports/Activities_____
Home Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Family Dentist_____ Family Physician_____ Email_____
School_____ Grade _____ **Is patient allergic to LATEX? Yes No**
Sibling(s):
Name_____ Birthdate_____ Name_____ Birthdate_____
Name_____ Birthdate_____ Name_____ Birthdate_____
Emergency Contact Person_____
Who/Whom may we thank for referring you to our office? _____

Family Information

Father's Name_____ Date of Birth_____ Social Security No_____
Father's Address_____ City_____ State____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ Email _____

Mother's Name_____ Date of Birth_____ Social Security No_____
Mother's Address_____ City_____ State____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ Email_____

Responsible Party Information

Who is the person responsible for the patient's account? Father__ Mother__ Other __ (please see below for other)
Other's Name_____ Date of Birth_____ Social Security Number_____
Other's Address (if different from patient's)_____ City_____State___ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Employer_____ Relationship to Patient_____

Orthodontic/Dental Insurance Information

Primary Dental Insurance:
Insured's Name_____ Relationship to Patient_____
Social Security Number_____ Date of Birth_____ Employer_____
Dental Insurance Carrier_____ Group/ID Number_____

Secondary Dental Insurance:
Insured's Name_____ Relationship to Patient_____
Social Security Number_____ Date of Birth_____ Employer_____
Dental Insurance Carrier_____ Group/ID Number_____

Health Questionnaire
Medical History

__Yes __No Is the patient in good health? If no, please explain_____
__Yes __No Is the patient currently being treated by a physician? If yes, please explain_____
__Yes __No Any previous hospitalization or serious illness? If yes, please explain_____
__Yes __No Is the patient allergic to latex?
__Yes __No Is the patient allergic to any medications? If yes, please list:_____
__Yes __No Is the patient taking any medications? If yes, please list:_____

Does the patient now, or have they ever had a history of any of the following (Mark Y or N):

__Y __N -Rheumatic Fever	__Y __N -Diabetes	__Y __N -Joint Replacement
__Y __N -Asthma	__Y __N -Lung Disease	__Y __N -Liver Disease
__Y __N -Severe Headaches	__Y __N -ADD/ADHD	__Y __N -Tuberculosis
__Y __N -Easy Bruising	__Y __N -Nose Bleeds	__Y __N -Eye Problems/Glaucoma
__Y __N -Kidney Problems	__Y __N -Anemia	__Y __N -Congenital Heart Defect
__Y __N -Yellow Jaundice	__Y __N -High Blood Pressure	__Y __N -Dizziness or Fainting
__Y __N -Ear Problems	__Y __N -Speech Problems	__Y __N -Venereal Disease
__Y __N -Heart Condition	__Y __N -Arthritis	__Y __N -Thyroid Problems
__Y __N -Hepatitis type ___	__Y __N -Low Blood Pressure	__Y __N -Convulsions/Seizures
__Y __N -Sinus Problems	__Y __N -Swallowing Problems	__Y __N -HIV Positive
__Y __N -Bisphosphonate Tx	__Y __N -Tumor/Cancer	__Y __N -Bone Disorders

Dental History

Does the patient have a chief concern about their teeth?_____
Date of most recent dental examination:_____
__Yes __No Has the patient had a previous orthodontic exam? If so, when_____
__Yes __No Has the patient had previous orthodontic treatment? If so, when_____
__Yes __No Has the patient's adenoids and/or tonsils been removed?

Does the patient now, or have they ever had a history of any of the following (Mark Y or N):

__Y __N -Injury to the Teeth/Jaws	__Y __N -Nail Biting	__Y __N -Joint Clicking/Popping
__Y __N -Grinding	__Y __N -Joint Pain	__Y __N -Snoring
__Y __N -Sleep Apnea	__Y __N -Gum Disease	__Y __N -Jaw Growth Disorder
__Y __N -Finger/Thumb Sucking	__Y __N -Mouth Breathing	__Y __N -Speech Problems
__Y __N -Headaches/Earaches	__Y __N -Tongue Thrust	__Y __N -Missing Teeth
__Y __N -Sensitive Teeth	__Y __N -Tobacco Use	__Y __N -Extra Teeth

Please elaborate on any items that were marked:_____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I authorize the Orthodontist to share this patient's treatment information with the collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

_____ _____ | _____
Signature of patient, guardian or responsible party Date Doctor's Initials