



OLYMPIC ORTHODONTICS

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PATIENT REGISTRATION HISTORY - CHILD

NAME _____ DATE ____/____/____
First Middle Last

BIRTH DATE ____/____/____ MALE FEMALE SCHOOL _____ GRADE _____

HOME ADDRESS _____
Street City State Zip

HOME PHONE _____ E-MAIL _____ CELL _____

MOTHER'S NAME _____ EMPLOYER _____ D.O.B. _____ PH# _____

FATHER'S NAME _____ EMPLOYER _____ D.O.B. _____ PH# _____

MOTHER'S SOCIAL SECURITY # _____ FATHER'S SOCIAL SECURITY # _____

PATIENT LIVES WITH BOTH PARENTS MOTHER FATHER OTHER

REFERRED BY? _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT ____/____/____

MEDICATIONS CURRENTLY TAKING:

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES NO

- Has patient had a physical exam in the last year?
- Is patient presently under a physician's care?
- Has patient ever been hospitalized?
- Is patient taking any pills, medication or drugs?
- Has patient ever had major surgery?

YES NO

- Has patient had any reactions to any medications?
- Has patient had his/her tonsils and/or adenoids removed?
- Does patient experience fainting or dizzy spells?
- Does patient have too high or too low blood pressure?

HAS PATIENT BEEN DIAGNOSED OR TREATED FOR:

YES NO

- Heart problems
- Kidney problems
- Rheumatic fever
- Lung problems
- Liver problems
- Endocrine problems
- Prolonged bleeding
- Tuberculosis
- Herpes

YES NO

- Hepatitis
- Allergies
- Diabetes
- Malignancies
- Anemia
- Arthritis
- Bone
- Asthma
- AIDS

PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

- Aspirin Codeine Penicillin Sulfa Latex Metals
- Other _____

Dr Notes:

MEDICAL ALERT
YES NO

Are there any other medical problems I should be aware of? _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____ DATE OF LAST CLEANING ____/____/____

YES NO

- Has patient ever had orthodontic consultations or treatment?
- Has patient been informed of any missing teeth?
- Have any permanent teeth been removed by extraction?
- Has a family member had orthodontic treatment?
Who? _____
- Does patient breathe predominately through his/her mouth?
- Does patient have any speech problems?
- Does patient now suck his/her thumb or finger?

YES NO

- Does patient grind or clench his/her teeth?
- Does patient have pain or clicking of the jaw joint?
- Has patient ever had any teeth injured due to an accident?
- Has patient ever had pains in the face ?
- Has patient ever had a severe jaw or head injury?
- Does patient want his/her teeth straightened?
- Does patient's gums bleed when brushing or flossing?

Are there any other dental/orthodontic problems I should be aware of? _____

PARENT/GUARDIAN SIGNATURE _____ DATE ____/____/____

DR SIGNATURE _____ DATE ____/____/____