Pediatric Dentistry and Orthodontics

Orthodontic Registration Form
Existing Wayne Smiles /Butler Smiles Patient

PATIENT INFORMATION

First Name_____ Last Name_____ Middle Name_____

Preferred Name/Nick Name_____ DOB_____ Age_____

Name of the parent accompanying the above child today_____

Relationship to Child: _____Mother _____Father _____Grandparent _____Legal Guardian

GENERAL ORTHODONTIC INFORMATION

What concerns you about your child's teeth?

_____

_____

What concerns your child about his/her teeth?

_____

_____

How does your child feel about the possibility orthodontic treatment?

_____

Who suggested that your child might need orthodontic treatment?_____

Has your child received orthodontic treatment in the past? **YES** **NO**
If yes, what type of treatment_____

Has your child had any other orthodontic consultations in the past? **YES** **NO**
If yes, describe any previous consultations and any recommendations made by the consulting orthodontist.

_____

_____

Does your child play a musical instrument? **YES** **NO**
If yes what instrument?_____

Do you think that any of your child's habits affect their face, teeth or jaws? **YES** **NO**
If Yes, How?

_____

_____

Have you noticed any unusual changes in your child's face or jaws? **YES** **NO**
If Yes, What have you noticed?

_____

_____

DETAILED PATIENT MEDICAL HISTORY

YES NO Birth defects or hereditary problems?
YES NO Bone fractures or major injuries?
YES NO Any injuries to face, head, neck?
YES NO Arthritis or joint problems?
YES NO Cancer, Tumor, Radiation Treatment or Chemotherapy?
YES NO Endocrine or thyroid problems?
YES NO Diabetes or low sugar?
YES NO Kidney problems?
YES NO Immune system problems?
YES NO History of osteoporosis?
YES NO History of any sexually transmitted disease?
YES NO AIDS or HIV positive?
YES NO Hepatitis, jaundice, or other liver problems?
YES NO Polio, mononucleosis, tuberculosis, pneumonia?
YES NO Seizures, fainting spells, neurologic problems?
YES NO Mental health disturbance or depression?
YES NO History of eating disorder (anorexia or bulimia)?
YES NO Frequent headaches or migraines?
YES NO High or low blood pressure?
YES NO Excessive bleeding or bruising, anemia?
YES NO Chest pain, shortness of breath, tires easily, swollen ankles?

YES NO Heart defects, heart murmur, rheumatic heart disease? ***IF YES*** *DOES YOUR CHILD REQUIRE PROPHYLACTIC ANTIBIOTICS PRIOR TO DENTAL TREATMENT* **YES NO**
YES NO Angina, arteriosclerosis, stroke or heart attack?
YES NO Skin disorder (other than common acne)?
YES NO Does your child eat a well-balanced diet?
YES NO Vision, hearing, or speech problems?
YES NO Frequent ear infections, colds, throat Infections?
YES NO Asthma, sinus problems, hayfever?
YES NO Tonsil or adenoid condition?
YES NO Does your child frequently breathe through his/her mouth?
YES NO Has your child ever taken Intravenous bisphosphonates such as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer ?
YES NO Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

If you answered yes to any of the above questions please explain:

_____

_____

HAS YOUR CHILD HAD ALLERGIES OR REACTIONS TO ANY OF THE FOLLOWING?

YES NO Local anesthetics (novocaine, lidocaine, xylocaine)
YES NO Latex (gloves, balloons)
YES NO Aspirin
YES NO Ibuprofen (Motrin, Advil)
YES NO Penicillin
YES NO Other antibiotics _____

YES NO Metals (jewelry, clothing snaps)
YES NO Acrylics
YES NO Plant pollens
YES NO Animals _____
YES NO Foods _____
YES NO Other substances_____

DETAILED DENTAL HISTORY

YES NO Erupting teeth very early or very late?
YES NO Primary (babY) teeth removed that were not loose?
YES NO Permanent or extra (supernumerary) teeth removed?
YES NO Supernumerary (extra) or congenitally missing teeth?
YES NO Chipped or injured primary or permanent teeth?
YES NO Any sensitive or sore teeth?
YES NO Any lost or broken fillings?
YES NO Jaw fractures, cysts, infections?
YES NO Any teeth treated with root canals or pulpotomies?
YES NO Frequent canker sores or cold sores?
YES NO History of speech problems or speech therapy?
YES NO Difficulty breathing through nose?

YES NO Mouth breathing habit or snoring at night?
YES NO History of speech problems?
YES NO Frequent oral habits (sucking finger, chewing pen)
YES NO Teeth causing irritation to lip
YES NO Clicking, locking in jaw joints?
YES NO Soreness in jaw muscles or face muscles?
YES NO Has your child been treated for "TMJ" or “TMD" problems?
YES NO Any broken or missing fillings?
YES NO Any serious trouble associated with previous dental treatment?
YES NO Has your child ever been diagnosed with gum disease or pyorrhea?

If you answered yes to any of the above questions please explain:

_____

_____

FAMILY ORTHODONTIC AND MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems?

Bleeding Disorders? **YES** **NO**
If yes please explain_____

Type I Diabete? **YES** **NO**
Type II Diabetes ? **YES** **NO**

Arthritis ? **YES** **NO**
If yes please explain_____

Severe Allergies ? **YES** **NO**
If yes please explain_____

Jaw size Imbalance? **YES** **NO**
If yes please explain_____

Unusual dental problems? **YES** **NO**
If yes please explain_____

Other family med conditions? **YES** **NO**
If yes please explain_____

Have the parents or siblings ever had orthodontic treatment? **YES** **NO**

If yes, who?_____
If yes, what type of treatment?
_____
_____

RELEASE AND WAIVER

I authorize release of any Information regarding my child's orthodontic treatment to my dental and/or medical Insurance for purposes of obtaining benefit information and pre treatment approvals.

I have read the above questions and understand them. I wIll not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made In the completion of this form. I will notify my orthodontist of any changes In my child's medical or dental health.

_____ _____
PARENT/GUARDIAN PRINT NAME RELATIONSHIP TO PATIENT

X_____ _____
PARENT/GUARDIAN SIGNATURE DATE

REVIEWED BY : Melissa Grieder-Roberto DMD

_____ _____
Orthodontist's Signature Date