PETTY & DRAGSTREM

ORTHODONTICS

CHILD REGISTRATION AND HEALTH HISTORY

Name ____ **Preferred Nickname** ____________________________________ **D.O.B.** _____/_____/_____

Home Address ____ **City** ___________________________________ **Zip** ____________________

Preferred contact for reminders, etc: Email ____**Cell phone**_________________________________

School____**Town**_________________________________

Favorite: Hobby/Sport________________________________ **Food**_____________________________________

Siblings:

Name______________________________**D.O.B.** _____/_____/_____ **Name**______________________________**D.O.B.** _____/_____/_____

Name______________________________**D.O.B.** _____/_____/_____ **Name**______________________________**D.O.B.** _____/_____/_____

Parent's Name____**Birthdate**____________________________

Occupation____

Cell Phone (if different than preferred) _________________________________

Home Address (if different than child) ____

Parent's Name____**Birthdate**_______________________________

Occupation____

Cell Phone (if different than preferred)_________________________________

Home Address (if different than child) ____

Marital Status of Parents: (Circle One) **Married** **Divorced** **Separated** **Single** **Widowed** **Partnership**

Name of Legal Guardian if not BOTH parents:____

Dentist ____ **City** ____

Reason For Consultation____

How did you hear about our office?____

THIS IS A TWO-SIDED FORM

DENTAL HISTORY

Approximate date of last dental check up______________________

For what procedure?_______________________________________

Any outstanding recommended dental work? If yes please explain:

____

How often do you:

brush? ________________________________

floss? ________________________________

Have you had fluoride treatments? o Yes o No

IF NO PERTAINS TO THE FOLLOWING, CHECK NO , IF YOU CHECK YES PLEASE EXPLAIN:

Any history of oral habits? o Yes o No
i.e., THUMB/FINGER SUCKING, nail biting, chewing pencils or ice, etc.?

____

Anxiety toward dentistry? o Yes o No

____

Injuries to the mouth or teeth? o Yes o No

____

Mouth breathing/snoring at night o Yes o No

____

Unusual speech habits? o Yes o No

____

ANY OF THE FOLLOWING CONDITIONS PRESENT? IF YES, PLEASE EXPLAIN:

Jaw joint problems? o Yes o No

____

Bruxing (tooth grinding)? o Yes o No

____

Tooth sensitivity? o Yes o No

____

Periodontal disease/Gum problems? o Yes o No

____

Tooth discoloration? o Yes o No

____

MEDICAL HISTORY

Approximate date of your last physical exam: _________________

Were you found to be healthy? o Yes o No

If not please briefly explain:________________________________

Are you under a physician's care now? o Yes o No

For what?____

Are you on medication now? o Yes o No

If yes, what medication? __________________________________

____

Have you ever been hospitalized? o Yes o No

If yes, please explain: ____________________________________

____

Do you have any allergies? o Yes o No

If yes, please explain:_____________________________________

Women: Are you pregnant or do you expect to be pregnant during treatment? o Yes o No

PLEASE MARK EACH CONDITION YOU HAVE A HISTORY OF, OR BEEN EXPOSED TO:

___ADD	___ADHD
___ASD	___Allergies
___Anxiety	___Bladder Disorders
___ Blood disorders	___Cancer
___Depression	___Epilepsy
___Hearing Disorders	___Heart problems
___Hormone/growth problems	___ Kidney Disorders
___Learning disability	___Liver Disorders
___Muscle disorders	___OCD
___Sexually Transmitted Diseases	___Skin disorders
___Thyroid disorders	

Is there anything not covered above that is important that I should know about for your health and well being? o Yes o No

____

Date: _________________ Updated: _________________

Signature: ____