Child Registration Form

Dubin Orthodontics
Established 1976

Patient's Name: _____ Nickname: _____

Birthdate: _____ ❑ Male ❑ Female ❑ Other Cell phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Patient Resides with (check all that apply): ❑ Father ❑ Mother ❑ Stepfather ❑ Stepmother ❑ Grandparent ❑ Guardian

Parents' Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

If remarried, spouse's name: _____

Special Interests or hobbies: _____

Patient's Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Whom may we thank for this referral: Dentist/Friend/Other(name): _____

Family member who have been patients (name/relationship): _____

Name of person accompanying child today: _____ Relationship: _____

SIBLINGS

Name	DOB	Sex	Name	DOB	Sex
_____	_____	❑ M ❑ F ❑ Other	_____	_____	❑ M ❑ F ❑ Other
_____	_____	❑ M ❑ F ❑ Other	_____	_____	❑ M ❑ F ❑ Other

PARENT/GUARDIAN INFORMATION

Mother/Stepmother/Guardian Name: _____ Social Security #: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Employer: _____ Current Position: _____

Father/Stepfather/Guardian Name: _____ Social Security #: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Employer: _____ Current Position: _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

Name: _____ Relationship: _____ Social Security #: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Employer: _____ Current Position: _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Policy or SS#: _____ Grp#: _____

Insured's Name: _____ DOB: _____

Relationship to Patient: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Policy or SS#: _____ Grp#: _____

Insured's Name: _____ DOB: _____

Relationship to Patient: _____

Insured's Employer: _____

MEDICAL HISTORY

	Please Circle			Please Circle			Please Circle	
Heart Murmur/Congenital Defect	Y	N	High Blood Pressure	Y	N	Asthma	Y	N
Heart Problems	Y	N	Convulsions/Epilepsy	Y	N	Latex Allergy	Y	N
Diabetes	Y	N	HIV/AIDS	Y	N	Hearing Impairment	Y	N
Rheumatic Fever	Y	N	Hemophilia	Y	N	Learning Disability	Y	N
Cancer	Y	N	Kidney/Liver Problems	Y	N	Special Needs	Y	N
Blood Transfusions	Y	N	Hepatitis	Y	N	Autism	Y	N
Operations/Stays in Hospital	Y	N	Sinus Problems	Y	N	ADD	Y	N
Fainting	Y	N	Headaches/Migraines	Y	N	ADHD	Y	N
Tuberculosis	Y	N	Allergies to Drugs	Y	N	Medications	Y	N
Other Medical Conditions	Y	N						

If you have circles **Yes** for any of the above, please explain: _____

_____

DENTAL HISTORY

	Please Circle			Please Circle			Please Circle	
Unfavorable Dental Experience	Y	N	Missing Teeth	Y	N	Cleft Lip/Palate	Y	N
Injuries to Face/Teeth	Y	N	Extra Teeth	Y	N	Late Tooth Eruption	Y	N
Pain/Noises in the Jaw Joint (TMJ)	Y	N	Speech Problems	Y	N	Other Orthodontic Txt	Y	N
Root Resorption	Y	N	Mouth Breathing	Y	N	Finger Sucking	Y	N
Periodontal Disease	Y	N	Gums Bleed	Y	N	Tongue Thrusting	Y	N
Antibiotics Prior to Dental Txt	Y	N	Grind Teeth	Y	N	Nail Biting	Y	N
Canker/Cold sores	Y	N	Chewing/Eating issues	Y	N	Chipped Teeth	Y	N

If you have circles **Yes** for any of the above, please explain: _____

_____

PARENTS' CONCERN(S): _____

MY CHILD'S CONCERN(S): _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

✓_____ ✓_____

Signature Date

We appreciate your efforts in fully completing this registration form. It assists our office in providing the best care possible.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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