PATIENT REGISTRATION

Date _____

Once completed, please print to PDF and send to bairdorthodontics@emaildds.com

CHILD AND GUARDIAN INFORMATION

Last Name *First Name* *Middle Initial*

Address _____

City _____

State_____Zip _____

Parent's Preferred Phone_____

Cellular provider _____

Child's School _____

Parent Email _____

Patient Dentist _____

Sex: ◯M ◯F Birthday_____

Whom may we thank for referring you? Please specify.

- ☐ Dentist: _____
- ☐ Google/Internet: _____
- ☐ Yelp: _____
- ☐ Friend: _____
- ☐ Family: _____
- ☐ Insurance Network: _____
- ☐ Instagram: _____
- ☐ Other (please specify): _____

_____

ADDITIONAL FAMILY INFORMATION

The following information is requested so that we can communicate properly with the people involved with your child's treatment. Please include the SS# only if you are planning on using Insurance benefits.

Patient's Parent

Last Name_____First Name _____

Address_____City_____State ____ Zip _____

Email _____

Preferred phone _____ ◯Cell ◉Home ◯Work

Occupation_____City _____

Patient's Parent

Last Name_____First Name _____

Address_____City_____State ____ Zip _____

Email _____

Preferred phone _____ ◯Cell ◯Home ◯Work

Name of Employer/Occupation_____City _____

If the parents do not reside together, whose name should be listed as the Responsible Party?

_____

Are the parents separated? ◯Yes ◉No Divorced? ◯Yes ◉No Remarried? ◯Yes ◉No

Who should receive routine information about treatment progress? _____

Other adults we should know about

Last Name_____First Name _____

Relationship to patient_____Phone #_____

Last Name_____First Name _____

Relationship to patient_____Phone #_____

Patient's siblings

Last Name_____First Name _____

Birth Date_____School_____

Last Name_____First Name _____

Birth Date_____School_____

Last Name_____First Name _____

Birth Date_____School_____

Has anyone else in the family been treated/seen at Baird Orthodontics? _____

INSURANCE INFORMATION

Is patient covered by dental insurance? If yes, please complete the following.

Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient_____Birthday _____ Name of Employer _____

Insurance Company _____ Contact # _____

Group # _____ Subscriber Soc. Sec. #_____Subscriber #_____

Delta/CA or Delta/State: _____ Employer Phone _____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

ADDITIONAL INSURANCE

Subscriber Name _____

Relation to Patient_____Birthday _____ Name of Employer _____

Insurance Company _____ Contact # _____

Group # _____ Subscriber Soc. Sec. #_____Subscriber #_____

Delta/CA or Delta/State: _____ Employer Phone _____

DENTAL HISTORY & STATUS

When were you last seen by a dentist? _____

◯ Yes ◯ No Is the patient taking any pills or medications for dental reasons? If yes, please elaborate

_____

◯ Yes ◯ No Have there been any unusual reactions to dental medications? If yes, please elaborate

_____

◯ Yes ◯ No Has the patient had trouble associated with dental treatment? If yes, please elaborate

_____

◯ Yes ◯ No Has the patient seen a periodontist, endodontist, or oral surgeon? If yes, please elaborate

_____

◯ Yes ◯ No Has the patient had previous orthodontic treatment or consultation? If yes, when?

_____

◯ Yes ◯ No Has any member of your family had orthodontic treatment? If yes, please elaborate

_____

◯ Yes ◯ No Has the patient had any teeth extracted? If yes, why?

_____

◯ Yes ◯ No Has the patient ever injured or broken any teeth? If yes, please elaborate

_____

◯ Yes ◯ No Has the patient ever been injured in the head or face? If yes, please elaborate

_____

◯ Yes ◯ No Does the patient have any missing or extra teeth? If yes, please elaborate

_____

◯ Yes ◯ No Does the patient have any problem with eating, chewing, or swallowing?

If yes, please elaborate _____

◯ Yes ◯ No Does the patient have any dental or facial pain? If yes, please elaborate

_____

◯ Yes ◯ No Does the patient's jaw joints make noise or hurt when opening, closing or chewing?

If yes, please elaborate _____

◯ Yes ◯ No Does the patient habitually grind or clench teeth together?

◯ Yes ◯ No Is the patient aware of any swellings or growths in the mouth or on the face?

If yes, please elaborate _____

◯ Yes ◯ No Does the patient have any negative or resistant feelings about orthodontic treatment?

◯ Yes ◯ No Is the patient especially concerned about orthodontic treatment?

◯ Yes ◯ No Is the patient dissatisfied with the appearance of his/her teeth?

◯ Yes ◯ No Is the patient specifically resistant to braces?

◯ Yes ◯ No Is the patient specifically resistant to headgear?

◯ Yes ◯ No Is there any other information we should know?

If yes, please elaborate _____

MEDICAL HISTORY

Who is the patient's physician?_____

Is this physician the same as the family physician? ◉ Yes ○ No

When was the patient last seen by a physician? _____

○ Yes ○ No Has the patient seen an ENT specialist, endocrinologist, neurologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? If yes, please elaborate: _____

○ Yes ○ No Is there a current medical problem? If yes, please elaborate _____

○ Yes ○ No Is the patient taking any pills, medications, or drugs? If yes, please elaborate _____

○ Yes ○ No Has the patient had an unusual reaction to any medication?

If yes, please elaborate _____

○ Yes ○ No Has the patient had a serious illness? If yes, please elaborate? _____

○ Yes ○ No Has the patient had any surgery or been hospitalized?

If yes, please elaborate _____

○ Yes ○ No Are there any congenital (that the patient was born with) problems? If yes, please elaborate

_____

What is the patient allergic to? _____

Has the patient ever been diagnosed or treated for any of the following?

○ Yes ○ No *Diabetes*	○ Yes ○ No *Anemia*	○ Yes ○ No *Liver problem*
○ Yes ○ No *Thyroid problem*	○ Yes ○ No *Jaundice*	○ Yes ○ No *Tonsilitis*
○ Yes ○ No *Sickle cell anemia*	○ Yes ○ No *Cancer*	○ Yes ○ No *Fainting*
○ Yes ○ No *Heart trouble*	○ Yes ○ No *Breathing trouble*	○ Yes ○ No *Epilepsy*
○ Yes ○ No *AIDS or HIV+*	○ Yes ○ No *Rheumatic Fever*	○ Yes ○ No *Tuberculosis*
○ Yes ○ No *Emotional problems*	○ Yes ○ No *Cerebral palsy*	○ Yes ○ No *Kidney problem*
○ Yes ○ No *Prolonged bleeding*	○ Yes ○ No *Arthritis*	○ Yes ○ No *Asthma*
○ Yes ○ No *Bone disease*	○ Yes ○ No *Hepatitis*	○ Yes ○ No *Low blood pressure*
○ Yes ○ No *Multiple sclerosis*	○ Yes ○ No *Stomach ulcers*	○ Yes ○ No *ADD/ADHD*
		○ Yes ○ No *Autism*

Reason for visit:

_____

_____

Parent Name _____

Parent Signature _____ Date _____

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