



## Pediatric Patient Registration & Health History

Date: \_\_\_\_\_

\*Patient's Name \_\_\_\_\_  
 Last Name First M.I. Nickname

\*Patient's Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ \*Home Phone # \_\_\_\_\_

\*Patient's Address \_\_\_\_\_  
 Street City State Zip Code

\*Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ \*Work Phone # \_\_\_\_\_

\*Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_ \*Work Phone # \_\_\_\_\_

\*Father's Cell Phone # \_\_\_\_\_ \*Mother's Cell Phone # \_\_\_\_\_

Father's Social Security # \_\_\_\_\_ Mother's Social Security # \_\_\_\_\_

Father's Address If Different \_\_\_\_\_ Phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Parent's Marital Status \_\_\_\_\_

### Insurance \*Do you have Orthodontic/Dental Insurance? Yes No

\*Orthodontic Insurance Provider \_\_\_\_\_

\*Subscriber's Name \_\_\_\_\_ \*ID # \_\_\_\_\_ \*Group # \_\_\_\_\_

\*Father's D.O.B. \_\_\_\_\_ \*Mother's D.O.B. \_\_\_\_\_

Secondary Orthodontic Insurance Provider \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

### Health Questionnaire

\*Physician \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

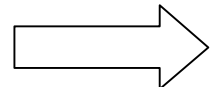
Do you have or have you had any of the following? Please check if it pertains to you.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Previous Hospitalization            | <input type="checkbox"/> Medication Allergies    | <input type="checkbox"/> X-rays {Medical/Dental}    |
| <input type="checkbox"/> Previous Surgeries                  | <input type="checkbox"/> Allergies Other         | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Tuberculosis                        | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Chest Pain                 |
| <input type="checkbox"/> Rheumatic Fever                     | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Murmur               |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Heart Attack               |
| <input type="checkbox"/> Kidney Disease                      | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> High Blood Pressure        |
| <input type="checkbox"/> Hepatitis A, B or C                 | <input type="checkbox"/> Recent Cold or Flu      | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Jaundice                | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Artificial Joints                   | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Anemia                              | <input type="checkbox"/> Nerve or Muscle Disease | <input type="checkbox"/> Chemo or Radiation Therapy |
| <input type="checkbox"/> Easy Bruising or Prolonged Bleeding | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Currently Pregnant         |



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**CONTINUED ON BACK**



# Health Questionnaire Continued

Do you have any other medical conditions not listed here? \_\_\_\_\_

List Medication Allergies (Including latex) \_\_\_\_\_

Are you currently under a physician's care?  Yes  No

Do you take medications?  Yes  No

If so, what kind? \_\_\_\_\_

Present Weight \_\_\_\_\_ Height \_\_\_\_\_

## Dental History

\*Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_

Date of your last dental checkup \_\_\_\_\_

Are there any current dental problems under treatment or not being treated? \_\_\_\_\_

Was there previous orthodontic treatment? \_\_\_\_\_

What prompted you to seek orthodontic treatment? \_\_\_\_\_

Is there now or was there a history of: If yes, please explain and give dates if possible.

YES  NO Thumb or finger habit \_\_\_\_\_

YES  NO Pacifier or bottle habit \_\_\_\_\_

YES  NO Fractured teeth \_\_\_\_\_

YES  NO Root canal \_\_\_\_\_

YES  NO Gum disease \_\_\_\_\_

YES  NO Clicking or pain while opening \_\_\_\_\_

YES  NO Injury to the face or jaws \_\_\_\_\_

YES  NO Is the nasal airway clear? \_\_\_\_\_ Do you breathe through your nose \_\_\_\_\_ mouth \_\_\_\_\_ both? \_\_\_\_\_

YES  NO Have you ever had a speech problem? \_\_\_\_\_ Speech therapy \_\_\_\_\_

YES  NO Has any other family member received orthodontic treatment with our office. If so, whom? \_\_\_\_\_

YES  NO Are there any problems, handicaps, or restrictions that may have a bearing on successful orthodontic treatment? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian's Signature

I certify that the information above is complete and accurate.

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