ARROWHEAD ORTHODONTICS

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.

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