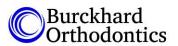


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Child/Adolescent Patient Registration

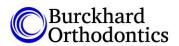
Today's date:/			
Patient name:	Nickname:Geno		ler:
Date of birth:/	_ Child by: birth or adoption	1	
Home phone: ()			
Patient's address:	City:	State:	Zip:
Grade: School:	City	:	
Patient's dentist:	Date of last cleanin	g and exam:	//
Patient's physician:			
Name(s) and ages of other children:			
Name(s) of other family members seen in our office: _			
Child/adolescent's hobbies and activities:			
Who is accompanying child/adolescent today:		Relationship: _	
How did you find out about our office:			
	arty/parent information		
Parent's Name:			
o Married o Widowed o Separated o Divorced o S			
Home phone: () Work			
Cell phone: () Emai			
Address:			
Employer:	Occupation:		
Parent's Name:			
o Married o Widowed o Separated o Divorced o S	single Spouse's name:		
Home phone: () Work Cell phone: () Emai			
<u> </u>			
Address:Employer:			
Employer:	Occupation:		
Who is the financially responsible party for the child/	adolescent:		
<u>Dental inst</u>	urance information		
***If you do have dental insurance, please bring the o	eard to your appointment.		
Orthodontic coverage: Yes No Lifetime maximum Primary insurance co. name:			
ID # Group #	Effective date	of coverage:	/ /
Address:			
Phone number: ()			r·
,			
Secondary insurance co. name:	Subscriber	Subscriber name:	
ID # Group #	Effective date	Effective date of coverage: / /	
Address:			
Phone number: ()			



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Patient's medical history

N Is the patient allergic to any medications/foods/other?					
N Is the patient currently taking any medications? If yes, who: If yes, for what reason: N Does the patient require pre-medication such as antibiotics for dental visits due to a medical configuration of the patient require pre-medication such as antibiotics for dental visits due to a medical configuration of the patient require pre-medication: N Abnormal bleeding Y N Depression Y N Hospital stays/s N AIDS / HIV positive Y N Diabetes Y N Kidney problem N ADHD / ADD Y N Disabilities Y N Liver problems N Anemia Y N Drug or alcohol dependence Y N Low blood pres N Anxiety Y N Epilepsy/seizures Y N Osteoporosis/O N Arthritis Y N Hearing problems Y N Rheumatic feve N Asthma Y N Heart attack Y N Speech problem N Autism Y N Heart disease Y N Sickle cell anem N Breathing problems Y N Hemophilia Type Y N Tuberculosis (T N Cancer Y N Hemophilia Type Y N Tobacco use If yes, what If yes, how much Males only N Pregnant	Is the patient allergic to any medications/foods/other?				
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N Does the patient require pre-medication such as antibiotics for dental visits due to a medical configuration of the indication for pre-medication: N Abnormal bleeding Y N Depression Y N Hospital stays/s N AIDS / HIV positive Y N Diabetes Y N Kidney problems N ADHD / ADD Y N Disabilities Y N Liver problems N Anemia Y N Drug or alcohol dependence Y N Low blood press N Anxiety Y N Epilepsy/seizures Y N Osteoporosis/O N Arthritis Y N Hearing problems Y N Rheumatic feve N Asthma Y N Heart attack Y N Speech problem N Autism Y N Heart disease Y N Sickle cell anem N Breathing problems Y N Heart murmur Y N Stroke N Cancer Y N Hemophilia Type Y N Tobacco use N Cleft lip/palate Y N High blood pressure If yes, what If yes, how much					
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If yes, how much					
nales only N Pregnant					
N Pregnant					
ves to any of the above, please explain:					
ves to any of the above, please explain:					
y other medical conditions:					



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Patient's dental history

W 	hy (lid you come to Burckhard Orthodontics:
Y	N	Does the patient want orthodontic care?
		Does the patient prefer: Braces Clear Aligners (Invisalign®, 3M TM Clarity TM) Open to either option
Y	N	Has the patient had any injuries to the face, mouth, teeth, or chin:
		Has the patient had a recent panoramic x-ray taken? If so, where:
		Has an orthodontist been consulted previously?
		If yes, who did you see and date of consultation:
Y	N	Has the patient been informed of any missing permanent teeth?
		Has the patient been informed of any extra permanent teeth?
		Thumb sucking habit
		Finger(s) sucking habit (any finger(s) other than the thumb)
		Lip sucking or biting
		Nail biting
		Clenching or grinding teeth
		Any clicking, popping, or jaw pain? If yes, please explain:
		Is the patient actively growing? Current height Current weight
		Any family member(s) who have had braces and where?
		Has the patient previous orthodontic treatment?
		If yes, where and when?
Aı	ıy o	ther dental conditions or issues:
Iŀ	ave	truthfully answered all of the questions and agree to inform Burckhard Orthodontics of any changes in the
_		t's contact information or medical/dental history. In addition, I authorize Burckhard Orthodontics to machine a complete orthodontic evaluation:
PC		m a complete of motivate evaluation.
Si	gnat	ture: Date:/
Re	lati	onship to patient: