Burckhard Orthodontics

700 Western Ave, Suite 100 Minot, ND 58701
701-838-1700 www.burckhardortho.com

Child/Adolescent Patient Registration

Today's date: _____/_____/_____
Patient name: _____ Nickname: _____Gender:_____
Date of birth: _____/_____/_____ Age: _____ Child by: birth or adoption
Home phone: (_____) _____
Patient's address: _____City: _____State: _____Zip: _____
Grade: _____ School: _____ City: _____
Patient's dentist: _____ Date of last cleaning and exam: _____/_____/_____
Patient's physician: _____ Clinic: _____
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: _____

Responsible party/parent information

Parent's Name: _____Gender: _____ Date of birth: _____/_____/_____
o Married o Widowed o Separated o Divorced o Single Spouse's name:_____
Home phone: (_____) _____ Work phone: (_____) _____
Cell phone: (_____) _____ Email address: _____
Address: _____City: _____State: _____Zip: _____
Employer:_____ Occupation: _____

Parent's Name: _____Gender: _____ Date of birth: _____/_____/_____
o Married o Widowed o Separated o Divorced o Single Spouse's name:_____
Home phone: (_____) _____ Work phone: (_____) _____
Cell phone: (_____) _____ Email address: _____
Address: _____City: _____State: _____Zip: _____
Employer:_____ Occupation: _____

Who is the financially responsible party for the child/adolescent: _____

Dental insurance information

*****If you do have dental insurance, please bring the card to your appointment.**

Orthodontic coverage: Yes No Lifetime maximum of coverage $ (if known):_____
Primary insurance co. name: _____ Subscriber name:_____
ID # _____Group # _____Effective date of coverage: _____/_____/_____
Address: _____City: _____State: _____Zip: _____
Phone number: (_____) _____

Secondary insurance co. name: _____ Subscriber name:_____
ID # _____Group # _____Effective date of coverage: _____/_____/_____
Address: _____City: _____State: _____Zip: _____
Phone number: (_____) _____

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Patient's medical history

Y N Is the patient in good health? If no, explain: _____
_____
Y N Does the patient have any history of major illness? _____
_____
Y N Is the patient allergic to any medications/foods/other? _____
_____
Y N Is the patient currently taking any medications? _____
_____
Y N Is the patient currently under the care of a physician?
If yes, who: _____
If yes, for what reason: _____
Y N Does the patient require pre-medication such as antibiotics for dental visits due to a medical condition?
If yes, what is the indication for pre-medication:_____

Y N Abnormal bleeding
Y N AIDS / HIV positive
Y N ADHD / ADD
Y N Anemia
Y N Anxiety
Y N Arthritis
Y N Asthma
Y N Autism
Y N Breathing problems
Y N Cancer
Y N Cerebral palsy
Y N Cleft lip/palate
Y N Depression
Y N Diabetes
Y N Disabilities
Y N Drug or alcohol dependence
Y N Epilepsy/seizures
Y N Hearing problems
Y N Heart attack
Y N Heart disease
Y N Heart murmur
Y N Hemophilia Type_____
Y N Hepatitis Type_____
Y N High blood pressure
Y N Hospital stays/surgeries
Y N Kidney problems
Y N Liver problems
Y N Low blood pressure
Y N Osteoporosis/Osteopenia
Y N Rheumatic fever
Y N Speech problems
Y N Sickle cell anemia
Y N Stroke
Y N Tuberculosis (TB)
Y N Tobacco use
If yes, what_____
If yes, how much_____

Females only
Y N Pregnant

If yes to any of the above, please explain: _____
_____
_____
_____
_____

Any other medical conditions: _____
_____
_____
_____
_____

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Patient's dental history

Why did you come to Burckhard Orthodontics: _____
_____
_____

Y N Does the patient want orthodontic care?
Does the patient prefer: Braces Clear Aligners (Invisalign®, 3M™ Clarity™) Open to either option
Y N Has the patient had any injuries to the face, mouth, teeth, or chin: _____
Y N Has the patient had a recent panoramic x-ray taken? If so, where: _____
Y N 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?
Y N Has the patient been informed of any extra permanent teeth?
Y N Thumb sucking habit
Y N Finger(s) sucking habit (any finger(s) other than the thumb)
Y N Lip sucking or biting
Y N Nail biting
Y N Clenching or grinding teeth
Y N Any clicking, popping, or jaw pain? If yes, please explain: _____
Y N Is the patient actively growing? Current height _____ Current weight _____
Y N Any family member(s) who have had braces and where? _____
Y N Has the patient previous orthodontic treatment?
If yes, where and when? _____

Any other dental conditions or issues: _____
_____
_____
_____
_____

I have truthfully answered all of the questions and agree to inform Burckhard Orthodontics of any changes in the patient's contact information or medical/dental history. In addition, I authorize Burckhard Orthodontics to perform a complete orthodontic evaluation:

Signature: _____ Date: _____/_____/_____

Relationship to patient: _____