

# PATIENT'S REGISTRATION FORM

GORDON M. ORGAN  
ORTHODONTIST



## PATIENT INFORMATION

PATIENT'S NAME \_\_\_\_\_ SEX \_\_\_\_\_  
(First Name) (Last Name)  M  F

ADDRESS \_\_\_\_\_ APT NO. \_\_\_\_\_

CITY \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

EMAIL \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_  
(Month) (Day) (Year)

FAMILY DENTIST \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_

WHO MAY WE THANK FOR RECOMMENDING US TO YOU? \_\_\_\_\_

REASON FOR PRESENTATION/CONCERNS: \_\_\_\_\_

## PARENT/RESPONSIBLE PARTY INFORMATION

MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

MARITAL STATUS:  MARRIED  SINGLE  
 SEPARATED  DIVORCED  WIDOWED

(if different from above)

ADDRESS \_\_\_\_\_

(City) (Postal Code)

HOME PHONE (\_\_\_\_) \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_

EMAIL \_\_\_\_\_

I hereby give Dr. G. Organ and/or members of his staff permission to release information concerning my child's dental and/or orthodontic health to the family or any other dentist or dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records and pertains to the initial condition, diagnosis, proposed treatment and treatment in progress.

\_\_\_\_\_  
(Date) X \_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
UPDATE 1 (Date) X \_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
UPDATE 2 (Date) X \_\_\_\_\_  
(Parent/Guardian Signature)

# PATIENT'S HEALTH QUESTIONS

	Yes	No	Not Sure
1 Is there a history in your family of irregular teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
protruding teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
congenitally missing teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Has any (other) member of your family had orthodontic treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Is your child's orthodontic problem obvious to you?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Is your child becoming self conscious because of his or her teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Does your child have frequent indigestion?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Did your child suck his or her thumb during: infancy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
after age 3?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
after age 7?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Does your child play any wind instruments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Has your child had any severe accidents involving his or her: teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
jaws?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lips?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Does your child have frequent: sore throats?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
colds?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
asthma?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hay fever?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other allergies?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Do you often notice that your child is breathing through his/her mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Has your child had his/her tonsils and adenoids removed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Has your child had any baby teeth extracted: because of decay?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
to make room for permanent teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
because they would not fall out normally?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 If baby teeth were extracted were space maintainers used to prevent closing of the extraction space?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 Has your child had any previous orthodontic treatment or consultation?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 Is your child in good general health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 Has your child had any of the following?			
heart trouble.....	<input type="checkbox"/>	abnormal blood pressure.....	<input type="checkbox"/>
lung disease.....	<input type="checkbox"/>	muscular dystrophy.....	<input type="checkbox"/>
kidney disease.....	<input type="checkbox"/>	speech problems.....	<input type="checkbox"/>
rheumatic fever.....	<input type="checkbox"/>	epilepsy.....	<input type="checkbox"/>
hepatitis, jaundice or liver disease.....	<input type="checkbox"/>	anaemia.....	<input type="checkbox"/>
blood disorders.....	<input type="checkbox"/>	AIDS or HIV positive.....	<input type="checkbox"/>
sinusitis.....	<input type="checkbox"/>	thyroid disease.....	<input type="checkbox"/>
diabetes.....	<input type="checkbox"/>	malignant hyperthermia.....	<input type="checkbox"/>
17 Is your child taking any medicines or drugs at the present time?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 Has your child experienced any unusual reaction to any of the following drugs? penicillin <input type="checkbox"/> aspirin <input type="checkbox"/> codeine <input type="checkbox"/> other medicine _____			
_____			
19 Is there anything that the orthodontist should know regarding your child's medical or dental history that has not been mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			
_____			
_____			
_____			
_____			