**Patient**

**Registration**

**(Please Print)**

**PATIENT INFORMATION**

Phone

Email

Date

Name of Minor/Child/Self

Preferred Name

Hobbies

Gender

Age

Birthdate

Sports

Home Address

Mailing Address

Street

Street

City

City

State

State

Zip

Zip

Person ﬁnancially responsible

Whom may we thank for referring you?

**DENTAL HISTORY**

Family/General Dentist

Date of last visit to a dentist

For what service

Prior orthodontic experience with other children in your family

Yes No

Yes No

Has child/self complained about dental problems?

Does child/self brush teeth daily?

Is ﬂuoride taken in any form?

Any previous injuries to mouth, teeth, or head?

Any unhappy dental experiences?

Does child/self use ﬂoss every day?

Any problems with gagging?

Any mouth habits - thumbsucking, tongue thrusting, grind teeth, mouth breathing, etc.?

**MEDICAL HISTORY**

Minor/Child/Self Physician

City/State

Phone

Date of last physical examination

Medical Conditions

Yes No

Is Minor/Child/Self under care of physician now?

Medications

Receiving any medication or drugs?

Ever been hospitalized?

Ever had surgery?

Allergies to medications/metals?

Other allergies

Is there excessive bleeding when cut?

Any speech problems?

HAS MINOR/CHILD/SELF HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO PLEASE CHECK ( √ )

Epilepsy

Kidney Disease

Liver Disease

Measles

Rheumatic Fever

Sinus Problems

Thyroid Disease

Tuberculosis

Other

A.I.D.S./H.I.V.

Anemia

Cerebral Palsy

Chicken Pox

Convulsions

Fainting

Asthma

Hearing Problems

Heart Problems/Murmur

Hepatitis

Mononucleosis

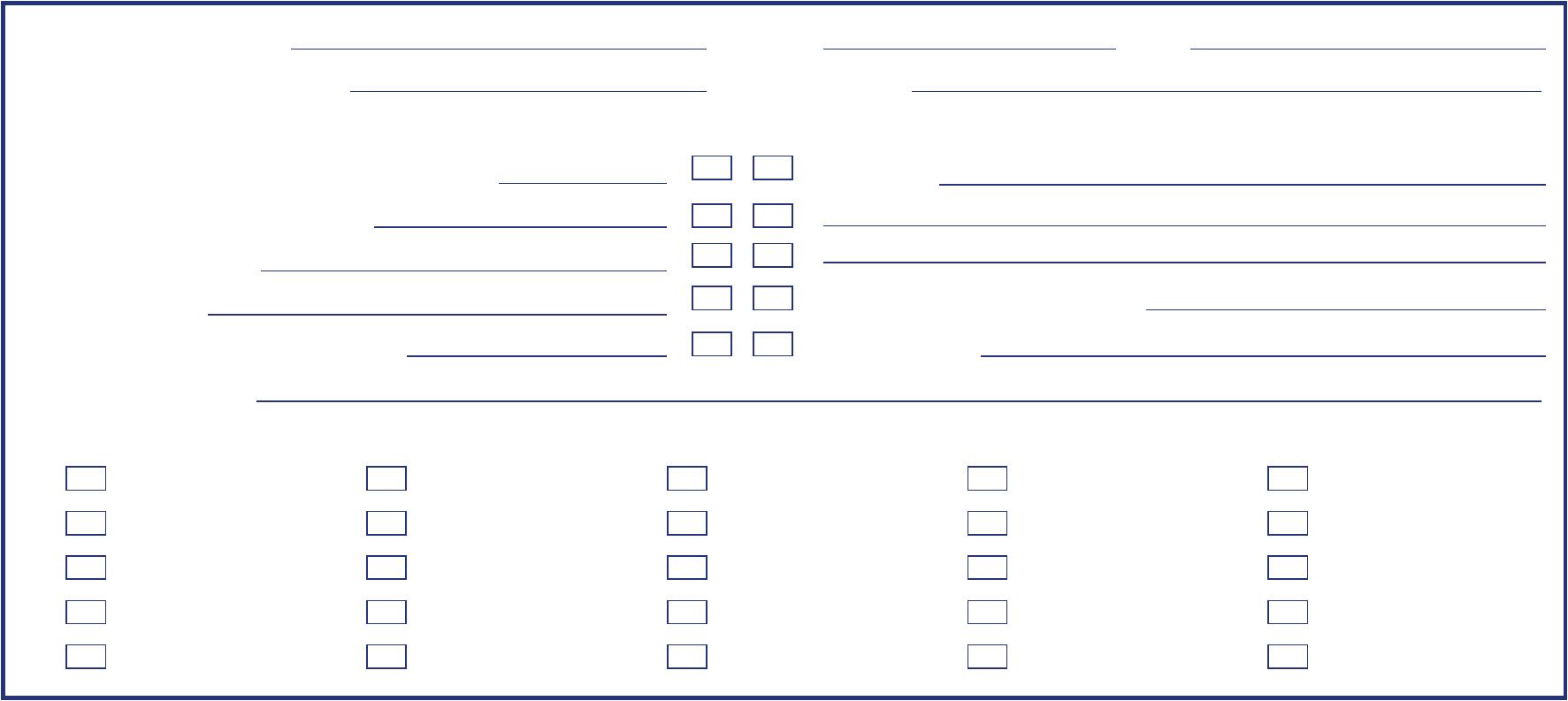
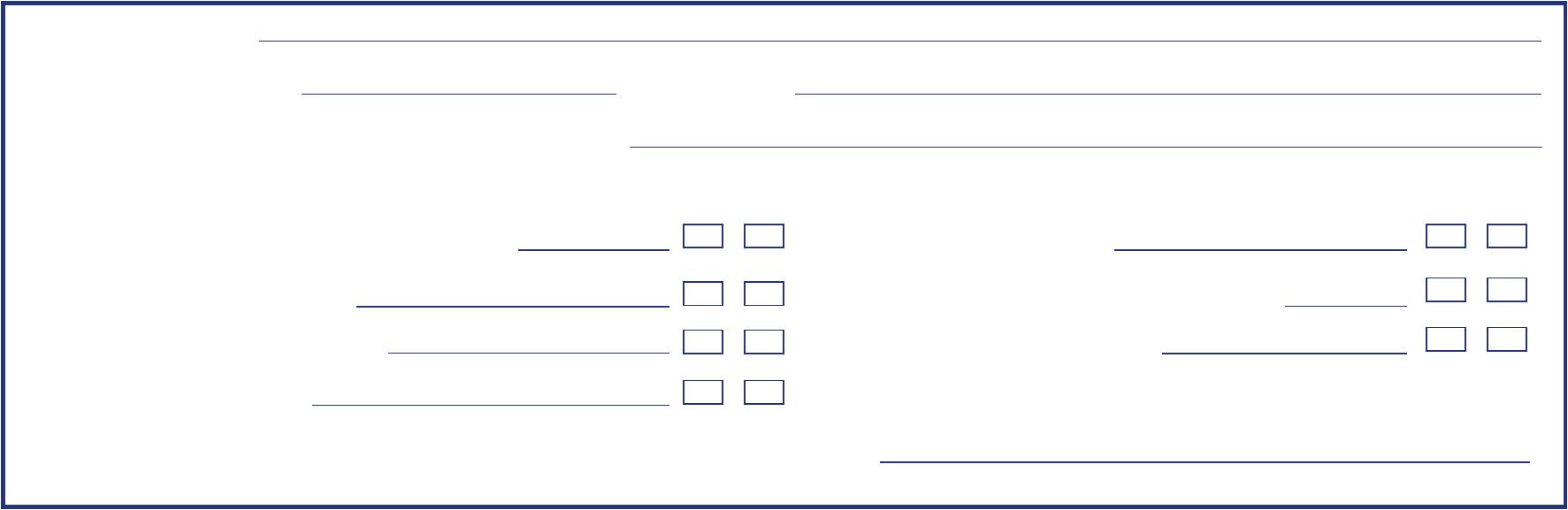
Mumps

Bleeding Problems

Cancer

Diabetes

Drug/Alcohol Abuse

ooxWord://word/media/image5.jpegooxWord://word/media/image6.jpegooxWord://word/media/image7.jpegooxWord://word/media/image8.jpegooxWord://word/media/image9.jpegooxWord://word/media/image10.jpegooxWord://word/media/image11.jpegooxWord://word/media/image12.jpegooxWord://word/media/image13.jpegooxWord://word/media/image14.jpegooxWord://word/media/image15.jpegooxWord://word/media/image16.jpegooxWord://word/media/image17.jpegooxWord://word/media/image18.jpegooxWord://word/media/image19.jpegooxWord://word/media/image20.jpegooxWord://word/media/image21.jpegooxWord://word/media/image22.jpegooxWord://word/media/image23.jpegooxWord://word/media/image24.jpegooxWord://word/media/image25.jpegooxWord://word/media/image26.jpegooxWord://word/media/image27.jpegooxWord://word/media/image28.jpegooxWord://word/media/image29.jpegooxWord://word/media/image30.jpegooxWord://word/media/image31.jpegooxWord://word/media/image32.jpegooxWord://word/media/image33.jpegooxWord://word/media/image34.jpegooxWord://word/media/image35.jpeg

**RESPONSIBLE PARTY INFORMATION**

Father’s/Guardian’s/Self Name

Mother’s/Guardian’s Name

Address (If different from patient’s)

Address (If different from patient’s)

Cell Phone

Home/Work

Cell Phone

Home/Work

Employer

Employer

Soc.Sec.#

Birthdate

Soc.Sec.#

Birthdate

Do you have dental insurance coverage for minor/child/self?

Yes

No

Do you have dental insurance coverage for minor/child/self?

Yes

No

**GENERAL INFORMATION**

What concerns you about your child’s/ your teeth?

What concerns your child about their teeth?

Why did you select our ofﬁce?

Describe any previous orthodontic treatment or consultations:

Have any other family members been treated in this ofﬁce? Please name them:

**AUTHORIZATIONS**

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest

of conﬁdence, and it is my responsibility to inform this ofﬁce of any changes in my child’s/own medical status. I authorize the

dental staff to perform the necessary dental services for my minor/child/self.

Signature of Parent/Guardian/Self

Date

**RELEASE AND ASSIGNMENT**

I certify that my minor/child/self is covered by insurance with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and assign directly to Tyska Alexander Orthodontics all insurance beneﬁts, if any, otherwise payable to me for services rendered.

I understand that I am ﬁnancially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release

all information necessary to secure the payment of beneﬁts. I authorize the use of this signature on all my insurance submissions,

whether manual or electronic.

Signature of Parent/Guardian/Self

Date

