



HIGGINBOTTOM
 — ORTHODONTICS —
 SMILE WITH STYLE

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CHILD REGISTRATION

Patient's Name	Nickname	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		Birthdate
City	State	Zip
School	Grade	Home Phone

RESPONSIBLE PARTY INFORMATION

Father's Name			Soc. Sec. #
Street Address			Email
			Home Phone
City	State	Zip	Cell Phone
			Business Phone
Father Employed by			Occupation
Employer's Address			
Mother's Name			Soc. Sec. #
Street Address			Email
			Home Phone
City	State	Zip	Cell Phone
			Business Phone
Mother Employed by			Occupation
Employer's Address			
Patient Lives With			
Have any of your other children been seen in this office?			<input type="checkbox"/> yes <input type="checkbox"/> no
If so, please list their names			
Friends treated here			

Patient name: _____

Reason for seeking orthodontic treatment		
How did you hear about our office?		
Whom may we thank for referring you?		
Person(s) financially responsible for this account	<input type="checkbox"/> Both parents	<input type="checkbox"/> Mother
	<input type="checkbox"/> Other	<input type="checkbox"/> Father

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please check YES or NO (If YES, please fill out details)

- YES NO Are you taking any medications? _____
- YES NO Are you allergic to any medication? _____
- YES NO Do you have a history of a major illness? _____
- YES NO Have you had any operations? _____
- YES NO Have you ever been involved in a serious injury? _____
- YES NO Have you seen a physician in the last 12 months? Why? _____
- YES NO Has the patient been ill for more than 5 days in the last 12 months? Name the illness: _____

Please check any of the medical conditions below that you have had or currently have:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Herpes | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma or Hayfever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gastrointestinal Disorder | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tumor or Cancer |
| <input type="checkbox"/> Back & Neck Pain | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Prolonged Bleeding | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Patient name: _____

DENTAL HISTORY

General Dentist _____ Date of Last Visit _____

Address _____ City _____ State _____

- Yes No Are you concerned about the appearance of your teeth? _____
- Yes No Do you have difficulty in chewing or swallowing your food? _____
- Yes No Have any of your teeth been removed by a dentist/oral surgeon? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes** **No** **Have there been any injuries to face, mouth, or teeth?** _____
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes** **No** **Do you have any type of thumb, finger or tongue habit?** _____ **Age when stopped** _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes** **No** **Has anyone in your family received orthodontic treatment?** _____
How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes** **No** **Are you aware of your jaw clicking or popping?** _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes** **No** **Do you bite your lips, tongue, fingernails, pencils or other objects?** _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in the ears? _____
- Yes No Do you have sleep apnea or do you snore? _____
- Yes** **No** **Have you had your tonsils or adenoids removed?** _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
- Yes No Does any member of your family or close relatives have a similar arrangement of teeth or a similar appearance in jaws? _____
- Yes No Do you brush your teeth in the morning? _____
- Yes No after lunch? _____
- Yes No after dinner? _____
- Yes No before bed? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Are the parents interested in having orthodontic treatment for appearance? _____
- Yes No better digestion? _____
- Yes No better speech? _____
- Yes No on the advice of a dentist? _____
- Yes No on the advice of friends? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Has the patient experienced a sudden increase in height? _____

Current height _____ Current weight _____

FEMALE PATIENTS ONLY:

Yes No Has menstruation started? _____ If so, when? _____
 Yes No Are you pregnant? _____

Patient name: _____

What is the patient's attitude toward receiving orthodontic treatment? _____

Please list some hobbies or interests _____

REVIEWED BY: _____ DATE: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of his team responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT _____