

WELCOME TO THE ORTHODONTIST
Child Patient Registration
(Please print legibly and provide all information requested.)

Patient: _____
(Last) (First) (M.I.)

MEDICAL HISTORY

In order to provide the patient with proper care it is essential that we know his or her medical history. Please answer **yes** or **no** to each question below. If you do not understand any of the questions or are unsure, please ask for help. Thank you for your cooperation.

1. Is the patient in good health? _____
2. Date of last physical examination _____
3. Is the patient under the care of a physician? _____

If yes, please explain: _____

Name & address of patient's physician: _____

4. Is the patient taking any medications or drugs? _____ (if yes, explain below)
5. Has the patient been hospitalized or been seriously ill in the past 5 years? _____ (if yes, explain below)
6. Is the patient allergic to any medication? _____ (penicillin, Novocain, aspirin, etc.) _____
7. Has the patient ever had excessive bleeding requiring special treatment? _____ (if yes, explain below)
8. Does the patient have a history of injecting drugs into his/her own body? _____
9. Does the patient have or has the patient had ANY of the following?

- | | | |
|------------------------------|------------------------------------------------|-------------------------------|
| Y N Heart Failure | Y N Emphysema | Y N AIDS/HIV+ |
| Y N Heart Disease/Attack | Y N Cough | Y N Hepatitis A |
| Y N Angina Pectoris | Y N Tuberculosis (TB) | Y N Hepatitis B |
| Y N High BP | Y N Asthma | Y N Liver Disease |
| Y N Low BP | Y N Hay Fever | Y N Yellow Jaundice |
| Y N Mitral Valve Prolapse | Y N Sinus Trouble | Y N Blood Transfusion |
| Y N Rheumatic Fever | Y N Allergies or Hives | Y N Drug Addiction |
| Y N Scarlet Fever | Y N Diabetes | Y N Hemophilia |
| Y N Heart Murmur | Y N Thyroid Diseases | Y N Venereal Disease |
| Y N Heart Pacemaker | Y N X-ray or Cobalt Treatment | Y N Cold Sores |
| Y N Artificial Heart Valve | Y N Chemotherapy | Y N Genital Herpes |
| Y N Heart Surgery | Y N Arthritis | Y N Epilepsy or Seizures |
| Y N Congenital Heart Disease | Y N Rheumatism | Y N Fainting or Dizzy Spells |
| Y N Artificial Joint | Y N Cortisone Medication | Y N Nervousness |
| Y N Anemia | Y N Glaucoma | Y N Psychiatric Treatment |
| Y N Stroke | Y N Clicking, Popping
or Pain in Jaw-Joints | Y N Sickle Cell Disease |
| Y N Kidney Trouble | Y N Mononucleosis | Y N Bruise Easily |
| Y N Ulcers | | Y N Handicaps or Disabilities |

10. Does the patient have any other disease, condition or problem not listed above? _____ (if yes, explain below)
11. Has the patient ever had any serious trouble associated with any previous dental treatment? _____ (if yes, explain below)

Women: Are you pregnant? _____ Do you anticipate becoming pregnant? _____ Do you take birth control pills? _____

Female Patients: Has menstruation begun? Y N If yes, at what age? _____ Age at which mother or older sister started _____

Explanations _____

GENERAL PHYSICAL DEVELOPMENT: Height _____ft. _____in. Weight _____lbs.

How many siblings does the patient have? ____Brothers ____ Sisters

CONSENT

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services that the patient may need during diagnosis and treatment with my informed consent.

Printed Name

Signature

Date

Michael N. Hage, DDS
Specialist – Orthodontics for Children and Adults
Invisalign Certified

276 Tompkins St. – Cortland – 607.753.3535

2333 N. Triphammer Rd., #201 – Ithaca – 607.319.5061

www.drhageorthodontics.com

Please complete all applicable information. Please print clearly.

Mother _____ Address _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ SS #: _____ Email: _____

Employer (name & address): _____

Dental Insurance: _____ ID #: _____

Father _____ Address _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ SS #: _____ Email: _____

Employer (name & address): _____

Dental Insurance: _____ ID #: _____

Step-Mother _____ Address _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ SS #: _____ Email: _____

Employer (name & address): _____

Dental Insurance: _____ ID #: _____

Step-Father _____ Address _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ SS #: _____ Email: _____

Employer (name & address): _____

Dental Insurance: _____ ID #: _____

Guardian _____ Address _____

Home #: _____ Cell #: _____ Work #: _____

DOB: _____ SS #: _____ Email: _____

Employer (name & address): _____

Dental Insurance: _____ ID #: _____