CAMBRIDGE PINE CITY ORTHODONTICS

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YOUTH PATIENT REGISTRATION

Date _____

Patient _____ Sex _____ Birthdate _____ Age _____
First M.I. Last

Address _____ City _____ State _____ Zip Code _____

Parent 1 / Legal Guardian _____ Birthdate _____
First M.I. Last

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Primary Phone (____)_____

Employer _____ Cell Phone (____)_____

Employer Address _____ Email Address _____

Orthodontic Insurance: No____ Yes ____ *If YES or unsure, please complete insurance information form.*

Parent 2 / Legal Guardian _____ Birthdate _____
First M.I. Last

Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Primary Phone (____)_____

Employer _____ Cell Phone (____)_____

Employer Address _____ Email Address _____

Orthodontic Insurance: No____ Yes ____ *If YES or unsure, please complete insurance information form.*

Person responsible for account _____

I hereby authorized this office to verify credit sources prior to making payment arrangements for orthodontic fees.

Signature of Responsible Person _____ Date _____

Patient's Dentist _____ City _____

Date of last dental exam _____ Date of last dental X-rays _____

Whom may we thank for referring you? _____

Names of other family members previously seen at our office: _____

I hereby authorize the release of any information relating to dental claims for benefits submitted on my behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Cambridge Pine City Orthodontics to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/ or dependents.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Cambridge Pine City Orthodontics.

Signature:_____ **Date:**____/____/____

(PLEASE COMPLETE BOTH SIDES)

Member American Association of Orthodontists

Patient Medical History

Patient's Physician _____ Clinic _____
Currently under a physician's care? _____ Reason _____
Have you been hospitalized in the last 5 years? _____ Reason _____
List all medications, nutritional supplements, herbal medicines, and/or non-prescription medications you are currently taking: _____

_____

Do you chew or smoke tobacco? _____ If no, have you ever? _____ If so, when did you quit? _____
Do your parents or siblings have any unusual dental problems or jaw size imbalance? _____

List all allergies including metal allergies: _____

_____

Has the patient ever had:	***YES***	***NO***
Abnormal Blood Pressure *(High _____ Low _____)*	_____	_____
AIDS or HIV Positive	_____	_____
Birth Defects or Hereditary Problems?	_____	_____
Bone Fractures and/or Major Accidents	_____	_____
Cancer, Tumor, Radiation or Chemotherapy?	_____	_____
Chemical Dependency *(Drugs, Alcohol)*	_____	_____
Diabetes: Diet Controlled	_____	_____
Insulin Controlled	_____	_____
Eating Disorder History (anorexia, bulimia)?	_____	_____
Endocrine or Thyroid Problems?	_____	_____
Epilepsy	_____	_____
Excessive Bleeding or Bruising Tendency, Anemia, or other Bleeding Problem?	_____	_____
Glaucoma	_____	_____

	YES	***NO***
Heart Problems: *(circle all that apply) (heart attack, angina, coronary insufficient, arteriorsclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)? Do you take Nitroglycerin?* _____	_____	_____
Hepatitis *(Circle A, B, C)*	_____	_____
Joint Replacement or Implant	_____	_____
Mental Health Disturbance or Depression?	_____	_____
Polio, Mononucleosis, Tuberculosis, or Pneumonia?	_____	_____
Rheumatic Fever	_____	_____
Stomach Ulcers or Hyperacidity?	_____	_____
Asthma	_____	_____
Women: Are you pregnant?	_____	_____
Are antibiotics required for dental work?	_____	_____

Have you ever taken **Fosamax, Zometa, Boniva, Actonel** or **Aredia** for osteoporosis or bone cancer? _____

_____

List other diseases, conditions or problems not listed above: _____

_____

Describe any serious injury to your face, jaw or mouth: _____

_____

Describe any problems with your jaw:

Clicking? _____
Pain (Joint, ear, side of face)? _____
Frequent headaches? _____
Difficulty in opening or closing? _____
Jaw ever locked or popped? _____
Clench or grind your teeth? _____
Have you ever had T.M.J. therapy? _____

I hereby acknowledge that the information given above is correct.

_____ _____

Signature of Responsible Person Date