IOWA CITY ORTHODONTICS

New Patient Registration Form-Child

Date________________________

Patient Name______________________________________ Sex________ Birthdate______________

Preferred Name______________________________ School________________________________

Address____ Home Phone #____________________

City__________________ State__________ Zip Code_______________

Father's Name_____________________________ Mother's Name_____________________________

Father's Employer__________________________ Mother's Employer__________________________

Father's Work/Cell #________________________ Mother's Work/Cell #________________________

Person responsible for making appts_______________________ Parents' Marital Status______________

Father's Address (if different than above)____

Mother's Address (if different than above)____

Person/People Responsible for Account____

Does the patient have orthodontic insurance?_____ Company__________________________________

Policy Holder Name____________________ DOB__________ Policy ID #______________________

Patient's Regular Dentist________________________________ Did they refer you here?_________

Date of Last Dental Exam___________ Patient's Physician_________________________________

Whom may we thank for referring you to our office?_______________________________________

Why are you are seeking orthodontic treatment?____

Has the patient been treated for any medical/psychological issues? (please list)___________________

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Is the patient taking any medications? (please list)_____________________________________

Has the patient had any injuries or operations involving the head, neck, or teeth?_________________

Please explain____

Is the patient allergic to anything (please list)____

Does the patient have a sensitivity to latex gloves?_____________________________________

Has the patient ever had pain/clicking/tenderness of the jaw joint (TMD/TMJ)____________________

Has the patient been informed of any missing or extra permanent teeth?______________________

Patient's Height_____________ Father's Height______________ Mother's Height______________

Does your child have a history of (Y/N):

Clenching/grinding teeth________ Lip sucking/biting__________

Thumb/finger sucking__________ Tongue thrust______________

It is important that the above information is correct and complete. It will be held in the strictest of confidence and used only for in-office treatment and paperwork. Your permission will be required to share given information with any other party.