WESTON ORTHODONTIC ASSOCIATES, INC.

CHILD PATIENT REGISTRATION & HISTORY

Patient's Name (Print)…… Today's Date…….
(First) (Middle Initial) (Last) (Month) (Day) (Year)

Address……..
(Street) (City) (State) (Zip Code)

Home Phone # ……. Age…….. Birthdate……
(Yrs. & Mos.) (Month) (Day) (Year)

School ……. Male ……. Female …….
(Name) (City) (Grade)

Referred By ……..

Father's Name…….. E-mail Address…..... Occupation……

Employer……. Work Phone #..... Cell Phone # ……..

Mother's Name…… E-mail Address…… Occupation…….

Employer…….. Work Phone #..... Cell Phone # …….

Parents' Marital Status…….. Dental Insurance Company, If Covered ……...

Dentist's Name …….. of …….
(City) (State)

Physician's Name …….. of ……..
(City) (State)

Other Children's Names & Ages ……..

MEDICAL AND DENTAL HISTORY (C)

Is the patient under medical treatment now? (Specify) ……

Is the patient presently taking any medications? (Specify) ……..……..

Has the patient had any major operations? (Specify)……...……

Has the patient ever had a serious accident involving head injuries? (Specify) ……

Has the patient ever had any allergic reaction to drugs including penicillin? (Specify) …….

Is there now or was there ever a history of:

Allergies ……...	Convulsions……...	Epilepsy……..	Anemia…….
Diabetes…….	Excessive Bleeding…….....	Asthma ……	Ear or Hearing Problem…
Heart Disease…….	Rheumatic fever…….	Hepatitis…… ..	HIV/AIDS……

What prompted you to seek orthodontic treatment? …….

Has the patient ever had a thumb or finger habit? ……

Does the patient breathe through the mouth or nose? ……...……...

Was there ever previous orthodontic treatment? ……..

Date of the last dental exam …….. Does the patient require antibiotics for dental procedures? ……...