CHILD'S NEW PATIENT REGISTRATION

TODAY'S DATE: _____

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Specialist in Orthodontics for Children & Adults

Child's Full Name: _____ Nickname: _____ Male/Female (Circle)
Birthdate: _____ Age: _____ SS #: _____ School: _____ Grade: _____
Home Address: _____ City: _____ State: ___ Zip Code: _____
Home #:_____ Childs's Hobbies/Sports: _____
List Brothers/Sisters w/Age: _____

Who is accompanying your child today? (Name) _____ Relation: _____
Do you have legal custody of this child? Y/N (circle)

Whom may we thank for your referral? ___ Phonebook ___ Insurance Co ___ Dentist _____ Friend _____
Website ___ If Internet, what did you Google? _____ Other _____

Parent's Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

	Mother's Information:	**Father's Information**:
Full Name:	_____	_____
Address:	_____	_____
City/St/Zip:	_____	_____
Home #:	_____	_____
Cell #:	_____	_____
Employer:	_____	_____
Work #:	_____	_____
SS #:	_____	_____
DL #:	_____	_____
E-mail:	_____	_____

Person(s) Financially Responsible for Acct:
Name(s): _____ Relation to child: _____
Billing Address: _____
City: _____ State: ____ Zip: _____ SS #: _____ DL #: _____
E-Mail: _____ Home #: _____ Cell/Other #: _____
Employer: _____ Work #: _____ Ext: _____

Person responsible for making Appointments:
Name: _____ Work #: _____ Home #: _____ Cell #: _____

Insurance Information:	**Primary:**	**Secondary:**
Ins. Co. Name:	_____	_____
Phone #:	_____	_____
Ins. Co. Address:	_____	_____
Insured's Name:	_____	_____
Relationship to Patient:	_____	_____
Insured's Birthday:	_____	_____
Insured's SS#:	_____	_____
Insured's Employer:	_____	_____
Effective Date:	_____	_____
Contract #:	_____	_____
Group #:	_____	_____
Lifetime Max:	_____ Payable @ %: _____	_____ Payable@%: _____
Age Limit for Ortho:	_____	_____
Waiting Period?	Y/N (circle) Period ends: _____	Y/N (circle) Period ends: _____

DENTAL HISTORY: **Date: _____**

Dentist Name _____ Last Visit _____ For what service? _____
Any injuries to the face, mouth, teeth, or chin? Y/N If Yes, describe _____
Does child have any habits? Y/N If Yes, please circle - thumb/finger sucking, lip sucking/biting, nail biting, mouth breathing, speech problems, clenching/grinding teeth, pacifier, tongue thrust).
Has your child been informed of any missing, or extra teeth? Y/N
Any unhappy dental experiences? Y/N If Yes, describe _____
Child's general attitude toward dentistry? _____
Any pain/tenderness in his/her jaw joint (TMJ) or difficulty chewing? Y/N _____

Does your child brush his/her teeth daily? Y/N Floss his/her teeth daily? Y/N Do you help your child brush/floss? Y/N
Are disclosing tablets used? Y/N Is Fluoride used in any form? Y/N

Has child ever been evaluated or had orthodontic treatment? Y/N (circle) If Yes, please give treatment details: _____
_____
What are the main concerns that you would like orthodontics to accomplish?
_____

MEDICAL HISTORY:

Child's Physician _____ Address _____ Phone _____
Date of last physical exam? _____ Is child under care of physician? Y/N If Yes, please describe _____
_____

Please list ALL drugs that child is currently taking:
Medication _____Taken for _____ Medication _____ Taken for _____
Medication _____Taken for _____ Medication _____ Taken for _____

Please indicate ALL allergies or reactions to the following:

Y/N	Aspirin	Y/N	Ibuprofen (Motrin, Advil)	Y/N	Vinyl	Y/N	Latex
Y/N	Acetaminophen (Tylenol)	Y/N	Metals, specify_____	Y/N	Acrylic	Y/N	Other, specify _____

Has your child had now or in the past had:

Y/N	Birth Defects or hereditary problems ?	Y/N	Asthma, sinus problems, hay fever or hives ?
Y/N	Rheumatoid or arthritic conditions ?	Y/N	History of eating disorder (anorexia or bulimia) ?
Y/N	Kidney problems ?	Y/N	Stomach ulcers or hyperacidity ?
Y/N	Hepatitis, Jaundice or liver problems ?	Y/N	Vision, hearing, tasting or speech difficulties ?
Y/N	Diabetes ?	Y/N	Skin disorders ?
Y/N	ENT problems ? (Tonsil or adenoids)	Y/N	Mental health or behavioral problems ?
Y/N	Endocrine or thyroid problems ?	Y/N	Does patient chew or smoke tobacco ?
Y/N	Immune system problems ?	Y/N	Is patient pregnant?
Y/N	Cancer, tumor, radiation treatment or chemotherapy ?	Y/N	AIDS or HIV positive ?
Y/N	Polio, mononucleosis, tuberculosis or pneumonia ?	Y/N	High or low blood pressure ?
Y/N	Fainting spells, seizures, epilepsy or neurological problems ?		
Y/N	Abnormal bleeding, excessive bleeding or bruising, or anemia ?		
Y/N	Heart Problems ? (murmur, rheumatic fever, heart defect, chest pain, etc)		

If so, explain _____
Y/N Any bone fractures, major accidents or any other problems ? _____
Y/N Any learning disabilities, handicaps or need extra help with instructions ?_____
Y/N Any hospitalizations or operations? If so, describe _____

Acknowledgment: I have read and understand the above registration form. I will not hold Dr. Bertha Dieguez-Marino or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. In addition, I have received a copy of this office's notice of privacy practices.
Consent to undergo Orthodontic Treatment: I hereby consent to the making of diagnostic records, including x-rays, before, during and after orthodontic treatment prescribed by the doctor as well as to the staff and doctor providing the prescribed orthodontic treatment for the above patient. I fully understand all of the risks associated with treatment.
Assignment of benefits: I hereby give permission to bill my insurance company for the services rendered by Dieguez-Marino Orthodontics P.C., and I agree to assist in the processing all claims for benefits. I hereby authorize direct payment of benefits to Dieguez-Marino Orthodontics P.C.
Financial Responsibility: I hereby agree to be responsible for all charges for services rendered to the patient including any non-covered charges. I also agree that if the unpaid account is referred to a collections agency, to pay all costs of collections, including reasonable fees of one-third of the balance due.

_____ _____

Responsible Party/ Relation to child **Responsible Party/ Relation to child / Date**