Adventure Dental
Pediatric Dentistry and Orthodontics

# Patient Registration

## All about your child

Name:_____ M/F
Last First MI

Nickname:_____ DOB: _____

School:_____ Grade:_____

Hobbies/Sports: _____

Who can we thank for referring you?

_____

## Medical Information

Child's Physician: _____ Ph: _____

Please list any medications your child is currently taking:

_____

Is your child in good health? ☐ Yes ☐ No

### Has your child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N Asthma
Y N Congenital Heart Defect
Y N Diabetes
Y N Hemophilia
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Hay fever/Sinus Problems
Y N Tuberculosis
Y N Allergic to latex/metals
Y N Allergic to Plastic
Y N Cancer
Y N Convulsions/Epilepsy
Y N Handicaps/Disabilities
Y N Heart Murmur
Y N Hepatitis
Y N Hospitalization
Y N Operations
Y N ADHD/ADD

Other/Please specify:

_____

Please list any drug allergies: _____

## Special Needs (If Applicable)

Diagnosis: _____

Are there any tips for addressing your child's needs?

_____

_____

Does your child see a therapist? ☐ Yes ☐ No

Child's Therapist: _____ Ph: _____

May we contact your child's therapist? ☐ Yes ☐ No

## Dental Habits

How often does your child brush? _____ Floss? _____

Is your child's water fluoridated? ☐ Yes ☐ No ZIP CODE: _____

Does your child take fluoride supplements? ☐ Yes ☐ No

When was your child's last dental visit? _____

### Has your child ever had any of the following habits?

Y N Clenching/Grinding
Y N Nail Biting
Y N Mouth Breathing
Y N Lip sucking/Biting
Y N Tongue Thrusting
Y N Thumb/finger Sucking

## Orthodontic Patients (If Applicable)

General Dentist: _____Ph: _____

Date of last exam? _____

What are your main concerns that you would like orthodontics to accomplish? _____

_____

Has your child ever had or been evaluated for orthodontic treatment?
☐ Yes ☐ No

Have there ever been any injuries to the face, mouth, teeth or chin?
☐ Yes ☐ No

Has your child ever been informed of any missing or extra permanent teeth?
☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

## Additional Notes (Office use only)

_____

_____

_____

_____

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

_____
Signature of Parent/Guardian Date

_____
Print name of Parent/Guardian Date

_____
Reviewed Date