PATIENT REGISTRATION

Date _____

CHILD AND GUARDIAN INFORMATION

Computer # _____ Office: _____

_____

Last Name *First Name* *Middle Initial*

Address _____
City _____
State _____ Zip _____
Parent's Preferred Phone (_____) _____

Home Phone (_____) _____

Child's School _____

Parent Email _____
Patient Dentist _____
Sex: ❑ M ❑ F Birthday _____/_____/_____

Whom may we thank for referring you? Please specify.

❑ Dentist: _____
❑ Google/Internet
❑ Yelp
❑ Friend: _____
❑ Family: _____
❑ Invisalign
❑ Berkeley Parents Network
❑ Other: (Please specify) _____

ADDITIONAL FAMILY INFORMATION

The following information is requested so that we can communicate properly with the people involved with your child's treatment.

Patient's Parent – Mr. / Mrs. / Ms. / Dr. / Prof. (Circle one)

Last Name _____ First Name _____
Home Phone _____ SS# _____
Address _____ City _____ State _____ Zip _____
Email _____
Work phone (preferred phone ❑)_____Cell Phone (preferred phone ❑) _____
Name of Employer _____ City _____

Patient's Parent – Mr. / Mrs. / Ms. / Dr. (Circle One)

Last Name _____ First Name _____
Home Phone _____ SS# _____
Address _____ City _____ State _____ Zip _____
Email _____
Work phone (preferred phone ❑)_____Cell Phone (preferred phone ❑) _____
Name of Employer _____ City _____

If the parents do not reside together, whose name should be listed as the Responsible Party? _____
Are the parents separated? ❑Yes ❑ No Divorced? ❑Yes ❑ No Remarried? ❑Yes ❑ No
Who should receive routine information about treatment progress? _____

Other adults we should know about

Last Name _____ First Name _____
Relationship to patient _____ Phone #_____
Last Name _____ First Name _____
Relationship to patient _____ Phone #_____

Patient's siblings

Last Name _____ First Name _____
Age _____ School_____
Last Name _____ First Name _____
Age _____ School_____

Has anyone else in the family been treated/seen at Berkeley/Orinda Orthodontics?

_____

INSURANCE INFORMATION

Is patient covered by dental insurance? ❑Yes ❑ No. If yes, please complete the following.
Is your insurance an ACA (Affordable Care Act) plan? ❑Yes ❑ No.

_____

Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient _____ Birthday _____
Name of Employer _____
Insurance Company _____
Contact # _____ Group # _____
Subscriber Soc. Sec. #_____
Subscriber #_____
Delta/CA or Delta/State: _____
Employer Phone (_____) _____

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

ADDITIONAL INSURANCE

1. Name of Policy Holder: _____

Birthday _____ Insurance Company _____
Contact # _____ Group # _____
Subscriber Soc. Sec. #_____

2. Name of Policy Holder: _____

Birthday _____ Insurance Company _____
Contact # _____ Group # _____
Subscriber Soc. Sec. #_____

DENTAL HISTORY & STATUS

When were you last seen by a dentist? _____

❑Yes ❑ No Is the patient taking any pills or medications for dental reasons? If yes, please elaborate _____

❑Yes ❑ No Have there been any unusual reactions to dental medications? If yes, please elaborate _____

❑Yes ❑ No Has the patient had trouble associated with dental treatment? If yes, please elaborate _____

❑Yes ❑ No Has the patient seen a periodontist, endodontist, or oral surgeon? If yes, please elaborate _____

❑Yes ❑ No Has the patient had previous orthodontic treatment or consultation? If yes, when? _____

❑Yes ❑ No Has any member of your family had orthodontic treatment? If yes, please elaborate _____

❑Yes ❑ No Has the patient had any teeth extracted? If yes, why? _____

❑Yes ❑ No Has the patient ever injured or broken any teeth? If yes, please elaborate _____

❑Yes ❑ No Has the patient ever been injured in the head or face? If yes, please elaborate _____

❑Yes ❑ No Does the patient have any missing or extra teeth? If yes, please elaborate _____

❑Yes ❑ No Does the patient have any problem with eating, chewing, or swallowing? If yes, please elaborate _____

❑Yes ❑ No Does the patient have any dental or facial pain? If yes, please elaborate _____

❑Yes ❑ No Does the patient's jaw joints make noise or hurt when opening, closing or chewing?

If yes, please elaborate _____

❑Yes ❑ No Does the patient habitually grind or clench teeth together?

❑Yes ❑ No Is the patient aware of any swellings or growths in the mouth or on the face?

If yes, please elaborate _____

❑Yes ❑ No Does the patient have any negative or resistant feelings about orthodontic treatment?

❑Yes ❑ No Is the patient especially concerned about orthodontic treatment?

❑Yes ❑ No Is the patient dissatisfied with the appearance of your teeth?

❑Yes ❑ No Is the patient specifically resistant to braces?

❑Yes ❑ No Is the patient specifically resistant to headgear?

❑Yes ❑ No Is there any other information we should know?

If yes, please elaborate _____

MEDICAL HISTORY

Who is the patient's physician? _____ Phone: _____

Is this physician the same as the family physician? ❑Yes ❑ No

When was the patient last seen by a physician? _____

❑Yes ❑ No Has the patient seen an ENT specialist, endocrinologist, neurologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? If yes, please circle all that apply.

❑Yes ❑ No Is there a current medical problem? If yes, please elaborate _____

❑Yes ❑ No Is the patient taking any pills, medications, or drugs? If yes, please elaborate _____

❑Yes ❑ No Has the patient had an unusual reaction to any medication? If yes, please elaborate _____

❑Yes ❑ No Have you had a serious illness? If yes, please elaborate? _____

❑Yes ❑ No Have you had any surgery or been hospitalized? If yes, please elaborate _____

❑Yes ❑ No Are there any congenital (that the patient was born with) problems? If yes, please elaborate _____

What is the patient allergic to? _____

Patient's Height _____ Weight _____

Has the patient ever been diagnosed or treated for any of the following?

❑Yes ❑ No *Diabetes*	❑Yes ❑ No *Anemia*	❑Yes ❑ No *Liver problem*
❑Yes ❑ No *Thyroid problem*	❑Yes ❑ No *Jaundice*	❑Yes ❑ No *Tonsilitis*
❑Yes ❑ No *Sickle cell anemia*	❑Yes ❑ No *Cancer*	❑Yes ❑ No *Fainting*
❑Yes ❑ No *Heart trouble*	❑Yes ❑ No *Breathing trouble*	❑Yes ❑ No *Epilepsy*
❑Yes ❑ No *AIDS or HIV+*	❑Yes ❑ No *Rheumatic Fever*	❑Yes ❑ No *Tuberculosis*
❑Yes ❑ No *Emotional problems*	❑Yes ❑ No *Cerebral palsy*	❑Yes ❑ No *Kidney problem*
❑Yes ❑ No *Prolonged bleeding*	❑Yes ❑ No *Arthritis*	❑Yes ❑ No *Asthma*
❑Yes ❑ No *Bone disease*	❑Yes ❑ No *Hepatitis*	❑Yes ❑ No *Low blood pressure*
❑Yes ❑ No *Multiple sclerosis*	❑Yes ❑ No *Stomach ulcers*	

Reason for visit:

_____

_____

Parent Signature _____Date_____

Print Name_____