CHILD PATIENT REGISTRATION

the office of Bridget Powers, D.D.S.,M.S.

TODAY'S DATE_____

1 PERSONAL INFORMATION

Name_____Gender_____Age_____Date of birth_____

Nickname (likes to be called) _____

Address_____

City, Zip_____

Email Address – for office use only_____ or_____

Home Phone_____Cell Phone_____

Person to contact in case of emergency_____

Relationship_____Contact phone_____

Patient's general dentist_____

Whom may we thank for mentioning our office? _____

Did you visit our website before this appointment? Y N Was that important to your decision? Y N

Has your child had previous orthodontic consultation or treatment? _____

What is the main reason you seek this consultation? _____

2 FAMILY INFORMATION (PARENTS/GUARDIANS)

Mother's Name_____Marital status: M S D W (circle one)

Date of Birth_____Employer_____Occupation_____

Cell Phone_____ Work Phone_____

Father's Name_____Marital staus: M S D W (circle one)

Date of Birth_____Employer_____Occupation_____

Cell Phone_____ Work Phone_____

OTHER GUARDIAN(S) WHO MAY BE BRINGING CHILD TO APPOINTMENTS_____

Are you the biological parents? _____Yes _____No

Siblings (Name/age)_____

ANY COMMUNICATION/PRIVACY ISSUES TO ADVISE OUR OFFICE_____

Is there any family history of the following? Circle one

☐	Jaw surgery	parent	sibling	other
☐	Impacted teeth	parent	sibling	other
☐	Short roots	parent	sibling	other
☐	Missing teeth	parent	sibling	other
☐	Headgear	parent	sibling	other

3 GETTING TO KNOW YOUR CHILD

School your child attends_____Grade_____

- Child's hobbies / Interests_____
- Please describe any significant fears or anxieties that your child may experience during visits to health care professionals (including dental)
  _____
  _____
- Has the anxiety or fear prevented any necessary treatment? Please describe:
  _____
  _____
- Are there any physical disabilities that need to be taken into consideration? (example: difficulty with fine motor skills)
  _____
  _____
- How does your child cope with physical discomfort?
  _____
  _____
- Are there learning disabilities that need to be taken into consideration?
  (examples: auditory processing difficulties, sensory integration dysfunction speech and language difficulties)
  _____
  _____
- Are there any strategies that help your child open up to new experiences such as a visit to a new doctor (examples: show and tell, humor, going very slowly, modeling with parent or other sibling, other examples)?
  _____
  _____
- Any additional information that might help us provide a positive office experience for your child?
  _____
  _____

4 MEDICAL HISTORY

While orthodontic treatments are obviously primarily confined to the mouth, your child's overall health status and medications he/she may be taking do have an effect on oral tissues and the biology of tooth movement. Therefore, we ask that you complete this part of the form and describe or explain questions you answer "yes". Dr. Powers will review this with you at the examination.
Name of your child's physician_____Date of last visit_____
Is your child:

Presently under any medical care or taking any medications? Y N Please explain:
_____

Any Allergies? _____

Are there any matters you would like to discuss in private?
_____

Any of the following (please circle)

Rheumatic fever	Attention deficit disorder	Endocrine disorder
Congenital heart lesions	Diabetes	Cancer
Heart trouble	Asthma	Immune system problems
High blood pressure	Tuberculosis (TB)	Hepatitis
Heart murmur	Arthritis	Other blood borne disease
Heart surgery	Bone disorder	Prolonged bleeding
Fainting	Neurological disorder	Hemophilia
Epilepsy/convulsions	Blood transfusion	Tonsil or Adenoids removed
Difficulty falling asleep	Snoring	Enlarged adenoids or tonsils

Is there any other medical history which has not been covered on this form? _____
_____
_____

5 DENTAL HISTORY

Patient's dentist_____Date of last dental visit_____

How often does he/she see the dentist_____

Decay /cavity experience? _____none _____limited _____extensive

Y N Does your child clench or grind her/his teeth at night?

Y N Does your child breathe mainly through her/his mouth?

Y N Does/did your child thumb or nail biting habits? Until what age: _____

Y N Has your child had any primary (baby) teeth removed?

Y N Are you aware of any naturally missing permanent teeth?

Y N Are you concerned about an underdeveloped or overdeveloped jaw?

Y N Has your child had any injury to her/his head, neck, jaw or teeth?

Y N Is your child aware of clicking, catch, popping or noises in jaw joints?

Y N Does your child have pain in or about her/his ears, temples, or cheeks?

Y N Does your child have pain or difficulty when chewing, talking, or using their jaw?

Y N Does your child's jaw get "stuck" , "locked" or "go out"?

Y N Does your child have frequent headaches?

Y N Does your child have speech difficulties?

Y N Does your child have gums that bleed?

Y N Has your child ever worn a bite plate or other orthodontic appliances?

Y N Does your child take antibiotics before dental procedures?

Y N Is there any other dental related history which might affect orthodontic treatment?

Y N Has your child seen any dental/orthodontic specialists? Please explain _____

_____

Y N Is it OK to discuss financial matters with your child present?

Y N Is it OK to discuss treatment matters with your child present?

Our office is HIPAA compliant and is committed to meeting the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical/dental status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need. I also authorize Dr. Powers and Smile Power Orthodontics to mail/email her exam findings to my/my child's dentist and myself.

Signature_____Date_____

Relationship to
patient_____