



# Orthodontic Registration and Acquaintance Card

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dentist: \_\_\_\_\_ Physician: \_\_\_\_\_

Whom may we thank for referring you to our practice? \_\_\_\_\_

What is the primary concern about your child's teeth? \_\_\_\_\_

**MEDICAL HISTORY** (Circle all current and past conditions)

- Heart Disease
- Heart Murmur
- Rheumatic Fever
- Stroke
- High or Low Blood Pressure
- Bleeding Disorder / Anemia
- Asthma
- Tuberculosis
- Diabetes
- Ear/Nose/Throat/Sinus Condition
- Endocrine / Thyroid Problems
- Hepatitis / Liver Disease
- Kidney or Bladder Disease
- Cancer
- Epilepsy/Seizures
- Arthritis
- Skin Disease
- MRSA
- Allergies
- HIV+/AIDS
- Psychological / Emotional Problems
- Eating Disorder
- ADD/ADHD
- Autism Spectrum
- Developmental Delay
- Headaches / Migraines
- Other (please list) \_\_\_\_\_

**DENTAL HISTORY** (Circle all that apply)

- Injuries to Teeth and/or Face (Describe) \_\_\_\_\_
- Finger/Thumb Sucking
- Lip Biting
- Mouth Breathing
- Jaw Joint (TMJ) Clicking/Locking/Pain
- Grinding or Clenching Teeth
- Fillings/Caps/Crowns/Veneers (Describe) \_\_\_\_\_
- Root Canals (Describe) \_\_\_\_\_
- Teeth Pulled (Describe) \_\_\_\_\_
- Oral or Facial Surgery (Describe) \_\_\_\_\_
- Periodontal (Gum) Treatment (Describe) \_\_\_\_\_
- Orthodontic Treatment (Describe) \_\_\_\_\_
- Sealants
- Fluoride Treatments
- Cold Sores or Canker Sores

**Please answer all of the questions that apply:**

- Medications taken regularly? (Describe) \_\_\_\_\_
- Allergic to latex? Yes \_\_\_\_\_ No \_\_\_\_\_
- Allergic to nickel? Yes \_\_\_\_\_ No \_\_\_\_\_
- Use illegal drugs? Yes \_\_\_\_\_ No \_\_\_\_\_
- Use tobacco in any form? Yes \_\_\_\_\_ No \_\_\_\_\_ (Describe) \_\_\_\_\_
- Ever had radiation treatment or chemotherapy? Yes \_\_\_\_\_ No \_\_\_\_\_
- Ever hospitalized over-night? (Describe) \_\_\_\_\_
- Date of last visit to dentist, and for what purpose? \_\_\_\_\_
- \_\_\_\_\_
- Date of last visit to physician, and for what purpose? \_\_\_\_\_
- \_\_\_\_\_

Is there anything else we should know about the medical, dental, or psychological history? \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Person(s) Responsible for this Account: \_\_\_\_\_

Orthodontic Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Employer: \_\_\_\_\_

Person to Notify in Case of Emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

To the best of my knowledge the above information is complete and correct. I hereby give permission to Dr. David M. Bunkall to examine my child and secure orthodontic diagnostic records. I also give Dr. Bunkall permission to verify my insurance coverage and, at his discretion, to run a credit check.

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_