commerce park dental group llc
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27 huntington plaza, huntington ct 06484, v:203.926.9929, f:203.926.1367
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orthodontic registration form

Date ____________

Patient Information

Last Name ____________ First Name ____________ Middle Initial ______ Sex ______

Prefers to be addressed by ____________ Date of Birth ____ / ____ / ____ Age (years) ______

Address ____________ Apt. # ______

City ____________ State ______ Zip ______ Home Telephone ______ Cell Phone # ______

Other family members treated at this office ____________

Parental Information

Mother

Name ____________

Date of Birth ____ / ____ / ____

Social Security # ____________

E-mail Address ____________

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Guardian

Employer ____________

Employer Address ____________

Employer Telephone ____________

Complete if **DIFFERENT** from patient's home information:

Home Address ____________

City ____________ State ______ Zip ______

Home Telephone ____________

Father

Name ____________

Date of Birth ____ / ____ / ____

Social Security # ____________

E-mail Address ____________

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Guardian

Employer ____________

Employer Address ____________

Employer Telephone ____________

Complete if **DIFFERENT** from patient's home information:

Home Address ____________

City ____________ State ______ Zip ______

Home Telephone ____________

Dental Insurance Information

(Please provide your insurance card to the receptionist)

Primary Insurance

Orthodontic Coverage ☐ Yes ☐ No

Company ____________

Address ____________

City ____________ State ______ Zip ______

Insurance Telephone ____________

Policy / Group # ____________

Policy Holder's Name ____________

Relationship to Patient ____________

Secondary Insurance

Orthodontic Coverage ☐ Yes ☐ No

Company ____________

Address ____________

City ____________ State ______ Zip ______

Insurance Telephone ____________

Policy / Group # ____________

Policy Holder's Name ____________

Relationship to Patient ____________

Referral Information

How did you hear about us? ☐Dentist ☐Family ☐Friend ☐Pediatrician ☐School Presentation ☐Web Site ☐Yellow Pages ☐Other

Name of person to thank for referral ____________

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DENTAL HISTORY

Patient's Dentist: ______________________ Date of Last Visit: ______________________

1. Have there been any injuries to the face, mouth or teeth? ☐ Yes ☐ No
2. Does the patient have any of the following habits? ☐ Thumb or finger sucking ☐ Lip Biting ☐ Grinding of teeth at night ☐ Mouth breathing ☐ Snoring ☐ No
3. Has the patient been informed of any missing or extra permanent teeth? ☐ Yes ☐ No
4. Has an orthodontist been consulted previously? ☐ Yes ☐ No

   Name: ______________________ Date: ______________________
5. Has the patient ever been treated for: ☐ Bad Bite ☐ TMJ ☐ Periodontal disease ☐ No

   If so, by whom? ______________________
6. Does the patient have any speech problems? ☐ Yes ☐ No
7. Is there anything the patient would like to change about his/her smile? ☐ Yes ☐ No

   If so, what: ______________________
8. Reason for consultation: ______________________
9. Has there ever been any orthodontic treatment for any siblings? ☐ Yes ☐ No

   Name ______________________ Doctor's Name ______________________

MEDICAL HISTORY

1. Is the patient's general health good at this time? ☐ Yes ☐ No
2. Name of physician? ______________________ Date of last physical: ______________________
3. Is the patient under the care of a physician at this time? ☐ Yes ☐ No

   Explain: ______________________
4. Is the patient taking any medication? ☐ Yes ☐ No If yes, what: ______________________
5. Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) ☐ Yes ☐ No

   If yes, what: ______________________
6. Does the patient have any other allergies (metals, latex, seasonal etc.) ☐ Yes ☐ No

   If yes, what: ______________________
7. Has the patient had tonsils and adenoids removed? ☐ Yes ☐ No Date: ______________________
8. Has the patient ever had a serious illness or been hospitalized? ☐ Yes ☐ No Date: ______________________

   Explain: ______________________
9. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treatments? ☐ Yes ☐ No

   If yes, antibiotic name and method: ______________________
10. Has the patient reached puberty? ☐ Yes ☐ No
11. Is there any other information that should be known about your child to make their appointments more pleasant?

    ____
12. Please check all conditions the patient has now or has ever had:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Endocarditis	☐	☐	Prosthetic (artificial) Joint	☐	☐	Blood Disorders/Bleeding Problems	☐	☐	Liver Disease
☐	☐	Heart Condition	☐	☐	X-Ray/Radiation (cancer) Therapy	☐	☐	Inflammatory Rheumatism	☐	☐	Psychiatric Treatment
☐	☐	Heart Pacemaker	☐	☐	AIDS or H.I.V. Positive	☐	☐	Arthritis	☐	☐	Drug Addiction
☐	☐	Heart Angina	☐	☐	Diabetes	☐	☐	Ulcers	☐	☐	Headaches
☐	☐	Heart Attack (coronary)	☐	☐	Respiratory Lung Disease	☐	☐	Stroke	☐	☐	Earaches
☐	☐	Mitral Valve Prolapse	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐	Jaw Clicking
☐	☐	Congenital Heart Disease	☐	☐	Low Blood Pressure	☐	☐	Asthma	☐	☐	Allergies
☐	☐	Artificial Heart Valve	☐	☐	Hepatitis (type?________)	☐	☐	Epilepsy	☐	☐	Jaw Pain
☐	☐	Heart Surgery date: ________	☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐	Tonsillitis
☐	☐	Heart Murmur	☐	☐	Venereal Disease	☐	☐	Fainting Spells	☐	☐	Allergies to any metals
☐	☐	Rheumatic Fever	☐	☐	Herpes (oral-cold sores)	☐	☐	Kidney Trouble	☐	☐	Emotional Problems
☐	☐	ADD	☐	☐	PDD	☐	☐	Developmentally Delayed			
☐	☐	Other: ______________________									

I certify that the information given is correct and give consent to Commerce Park Dental Group to treat my child.

Signature ______________________ Date ______________________

(Please Circle One) PARENT GUARDIAN OTHER

Reviewed by ______________________ Date ______________________