MINOR REGISTRATION

PATIENT NAME _____
LAST FIRST MIDDLE NICKNAME DATE

_____
HOME ADDRESS CITY STATE ZIP

_____
HOME PHONE BIRTHDATE AGE GRADE/SCHOOL SEX

FATHER'S NAME _____
LAST FIRST SS# OCCUPATION WORK PHONE

MOTHER'S NAME _____
LAST FIRST SS# OCCUPATION WORK PHONE

_____
EMAIL SIBLINGS/AGES

WHO MAY WE THANK FOR REFERRING YOU? _____

PERSON RESPONSIBLE FOR ACCOUNT _____

PRIME INSURED	RELATIONSHIP:	SECONDARY INSURED	RELATIONSHIP:
SS#	D.O.B.	SS#	D.O.B.
EMPLOYER:		EMPLOYER:	
INS. CO.:		INS. CO.:	
INS. ADD.:		INS. ADD.:	
GROUP#/LOCAL:		GROUP#/LOCAL:	

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health and orthodontic treatment. I will review this history with you at the initial examination. Information you give me is strictly confidential and will not be released without your permission.

MEDICAL HISTORY

PHYSICIAN'S NAME DATE OF LAST VISIT

ADDRESS (Street) PHONE

CITY STATE ZIP

YES	NO	
❒	❒	HAS THE PATIENT UNDERGONE A PHYSICAL EXAM DURING THE PAST YEAR?
❒	❒	IS THE PATIENT PRESENTLY UNDER A PHYSICIAN'S CARE?
❒	❒	HAS THE PATIENT HAD MAJOR SURGERY?
❒	❒	HAS THE PATIENT EVER BEEN HOSPITALIZED?
❒	❒	IS PATIENT TAKING ANY PILLS, MEDICATIONS OR DRUGS?
❒	❒	IS PATIENT ALLERGIC TO NOVOCAINE OR PENICILLIN?
❒	❒	HAS PATIENT HAD ANY UNUSUAL REACTION TO ANY MEDICATION?
❒	❒	HAS PATIENT HAD TONSILS AND/OR ADENOIDS REMOVED?
❒	❒	DOES PATIENT HAVE FAINTING OR DIZZY SPELLS?
❒	❒	DOES PATIENT HAVE A TOO HIGH OR LOW BLOOD PRESSURE?

HAS PATIENT BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING?

Yes	No		Yes	No	
❒	❒	HEART PROBLEMS	❒	❒	HEPATITIS/HIV
❒	❒	KIDNEY PROBLEMS	❒	❒	RHEUMATIC FEVER
❒	❒	LUNG PROBLEMS	❒	❒	EMOTIONAL PROBLEMS
❒	❒	LIVER PROBLEMS	❒	❒	MALIGNANCIES
❒	❒	ALLERGIES/LATEX	❒	❒	ENDOCRINE PROBLEMS
❒	❒	DIABETES	❒	❒	BONE DISORDER
❒	❒	EPILEPSY	❒	❒	PROLONGED BLEEDING
❒	❒	ARTHRITIS	❒	❒	TUBERCULOSIS
❒	❒	ANEMIA	❒	❒	ASTHMA

❒ ❒ ARE THERE ANY OTHER MEDICAL PROBLEMS NOT LISTED?

DENTAL HISTORY

DENTIST'S NAME DATE OF LAST VISIT

ADDRESS (Street) PHONE

CITY STATE ZIP

WHAT IS THE MAJOR CONCERN ABOUT THE PATIENT'S TEETH? _____

YES	NO	
❒	❒	HAS PATIENT HAD PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT?
❒	❒	HAS PATIENT BEEN INFORMED OF ANY EXTRA OR MISSING TEETH?
❒	❒	HAVE ANY PERMANENT TEETH BEEN REMOVED BY EXTRACTION?
❒	❒	HAS ANY FAMILY MEMBER HAD ORTHODONTIC TREATMENT? WHO? _____
❒	❒	DOES PATIENT NOW SUCK HIS/HER THUMB OR FINGER?
❒	❒	DOES PATIENT BREATHE PREDOMINANTLY THROUGH THE MOUTH?
❒	❒	DOES PATIENT HAVE ANY SPEECH PROBLEMS?
❒	❒	DOES PATIENT GRIND OR CLENCH HIS/HER TEETH?
❒	❒	DOES PATIENT HAVE PAIN OR CLICKING OF THE JAW JOINT?
❒	❒	HAVE ANY TEETH BEEN INJURED OR CHIPPED DUE TO AN ACCIDENT?
❒	❒	HAS PATIENT EVER HAD PAINS IN THE FACE OR HEAD?
❒	❒	HAS PATIENT EVER HAD SEVERE JAW OR HEAD INJURY?
❒	❒	DO PATIENT'S GUMS BLEED ON BRUSHING OR FLOSSING?
❒	❒	IS PATIENT CONCERNED ABOUT APPEARANCE OF HIS/HER TEETH?
❒	❒	DOES PATIENT WANT HIS/HER TEETH STRAIGHTENED?
❒	❒	ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS I SHOULD BE AWARE OF?

I acknowledge I have received from the office of Dr. Andrew Kouvaris, a copy of the Notice of Privacy Practices.

PARENT/GUARDIAN SIGNATURE _____ DATE _____