New Patient Registration

Patient's name: _____ _____ M / F / NB Birthdate ___/____/____ Age_____
first last d m y

Address: _____ Town/City: _____ Postal Code: _____

Parent / Guardian:_____ Parent / Guardian_____

Home #: _____ Work # 1: _____ Work # 2_____

Cell phone # _____ Email Address: _____

I hereby give my permission to send correspondence by Email:_____

Medical History

Does the patient have or has ever had any of the following?

Epilepsy/seizures	Asthma	Heart murmur
Rheumatic fever	Kidney disease	HIV positive status/AIDS
Diabetes/insulin dependant	Hay fever	Leukemia/Cancers
Liver disease/Hepatitis	Heart disease	Mental health disorders/treatment
Eating disorders (anorexia/bulimia)	Head/facial injuries	Blood disorders
Arthritis	Tuberculosis	Bronchitis
Blood Pressure	Joint Replacements	

Other conditions: _____
Allergies: _____
Drug allergies: _____
List of current medications and dosage: _____
Is there any chance the patient could be pregnant? Yes No
Is medication required prior to dental treatment? (i.e. for heart conditions) Yes No
If yes, name of medication and dosage required _____
Tonsils and adenoids? present ____ absent ____

Dental History

Name of family dentist _____ Location _____

Does the patient visit their dentist regularly?	Yes	No
Any discomfort when chewing, opening or closing mouth?	Yes	No
History of vehicle accident or experienced blows to the jaw?	Yes	No
Do gums bleed when brushing?	Yes	No
Does the patient smoke or use chewing tobacco?	Yes	No
Has any other family member had braces?	Yes	No

Name of family member (if treated in our office) _____

How did you come to hear of our office? _____

I hereby give my permission to use my photos for media, in office, internet and advertising. Yes____ NO _____

PLEASE TURN PAGE FOR ADDITIONAL INFORMATION

Children under 16 please fill out the following:

Please indicate if your child experiences any of the following:

__ Snoring
__ Difficulty Falling Asleep
__ Difficulty Staying Asleep
__ Restless Sleep
__ Night Terrors
__ Excessive Daytime Sleepiness
__ Chronic Mouth Breathing
__ Bed Wetting
__ Dental Crowding
__ Speech Difficulties
__ History of Respiratory Infections (Ear, Nose, Throat)

All others 16 and over please fill out the following:

1. Have you ever been told that you need to wear CPAP for sleep? Yes__ No __
2. Do you use over the counter medication for headache pain or as a sleeping aid? Yes__ No__
3. Is it easy for you to get to sleep? Yes__ No__ Do you wake often? Yes__ No__
4. Do you feel rested when you wake in the morning? Yes__ No__
5. Do you experience sounds like popping or clicking in the jaw joints? Yes__ No__

Release of Information

I hereby give Dr. Frackowiak and/or members of her staff permission to release information concerning my child or my own dental and/or orthodontic health to the family physician, dentist or any other dental specialist as is deemed necessary from time to time. Such information includes x-rays and other diagnostic records which pertains to the initial condition, diagnosis, proposed treatment or treatment in progress.

Dental/Orthodontic Insurance

Dental insurance is a contract between you, your employer and your insurance company. We are unable to accept assignment/payment directly from your insurance carrier. Since every insurance company has different policies, please confirm your coverage prior to active treatment (orthodontic coverage usually ranges from 50 –75% to a lifetime maximum outlined in your insurance contract). We regret that we are unable to electronically file your claim forms.

_____ _____

Date ***Signature***