

New Patient Registration

Patient's name: _____ M/F Birthdate ___/___/___ Age _____
First Last m d y

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

Home #: _____ Cell #: _____ Email: _____

Father's name (if applicable): _____ Occupation: _____ Work #: _____

Mother's name (if applicable): _____ Occupation: _____ Work #: _____

Do you have a benefit plan that covers orthodontic treatment? Yes No Insurance carrier: _____

Parent's marital status: single/married/separated/divorced/widowed

Medical History

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

Epilepsy/Seizure	Arthritis	Tuberculosis	Eating disorder: Anorexia, bulimia
Rheumatic fever	Asthma/ Bronchitis	Disability	Psychiatric disorder
Diabetes/ insulin dependant	Kidney disease	HIV positive/ AIDS	Heart murmur/ Heart defect
Liver disease/ Hepatitis	Hay fever	Leukemia/Cancer	Blood disorder/ Hemophilia

Allergies to drugs, nickel, latex or any other? _____

Describe any conditions or diseases not listed above. _____

Is there any chance the patient could be pregnant? Yes No

Have your tonsils or adenoids been removed? Yes No

Dental History

Name of general dentist _____ Location _____

Does the patient visit their dentist regularly? Yes No

Any discomfort when chewing, opening or closing mouth? Yes No

History of accident or trauma to teeth or 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 many ways have you heard about our office

Family member Friend General Dentist LA Ortho Employee Office Sign
 Website Facebook Google Flyer Newspaper Direct Mail School

Release of Information

I hereby give Dr. Lee and Dr. Antoniazzi and/or members of their staff permission to release information concerning my child or my own dental and/or orthodontic health to the family physician, dentists or any other dental specialist as is deemed necessary. Such information includes x-rays and other diagnostic records, pertaining to the initial condition, diagnosis, proposed treatment, or treatment in progress.

_____ *Date*

_____ *Signature*