CAYMAN ORTHODONTICS
Patient Registration Form

Patient Name:_________________________________Nickname:______________________

Date of Birth:_______/_______/_______ Age:__________ Sex: M/F

Home Phone:_________________________ Cell Phone: ________________________

Work Phone:_________________________

PO Box:__________________ KY ________-___________

General Dentist's Name____

Dental Insurance Y/N, if yes Insurance Company:_______________________________

How did you hear about our office? Please circle:

Dentist/ Friend/ Family member is a patient/ Internet/ Other

Name:____

What is your main concern today?____

Complete this section if patient is a child
(Parent/Guardian/Person Responsible for Account)

Mother's Name:_______________________________ Single/ Married/ Divorced/ Widowed

PO Box (If different from above): __________________ KY ________-___________

Main Phone (if different from above): __________________

Father's Name: ________________________________ Single / Married/ Divorced/ Widowed

PO Box (If different from above): __________________ KY ________-___________

Main Phone (if different form above):______________________________________

Please complete health history on the back.

Please understand our facility has an open concept which helps create a friendly, welcoming office atmosphere. During treatment, you will be in this area during your orthodontic appointments. We do have a private room if you decide this open concept is not for you.

In order to provide safe dental care for our patients, we ask that you complete the following questionnaire as accurately as possible.

Date of your last dental examination: ______________________Where:______________________

Have you ever had previous orthodontic consultation or treatment? ☐ Yes ☐ No

Where:____

Any family members require or receive orthodontic treatment? ☐ Yes ☐ No

Where:____

Please check if the patient has history of:

__ Thumb (finger) sucking (past/present) __ Clenching teeth __ Jaw joint soreness

__ Grinding teeth __ Jaw joint clicking __ Tongue thrusting

__ Muscular soreness around head and neck __ Jaw joint popping __ Mouth Breathing

__ Headaches more than normal __ Ringing in the ears __ Lip biting

Additional information or explanation: _______________________________________

____

Present state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any general health problems OR is the patient currently under a physician's care? ☐ Yes ☐ No

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____

Is the patient currently taking any medications for Osteoporosis or other none disease (Bisphosphonates)? ☐ No ☐ Yes

Please list current drugs/medication____

List any drug allergies or sensitivity ____

Please check if you have a history of (check appropriate boxes)

☐ Rheumatic fever	☐ Hepatitis	☐ Aids/HIV
☐ Mouth Breathing (awake or asleep)	☐ Difficulty in chewing or swallowing	
☐ Tuberculosis	☐ Convulsion	☐ Speech impediments
☐ Blood disease	☐ ADD/ADHA	☐ Anemia
☐ Bone disorder	☐ Autism	☐ Diabetes
☐ Jaundice	☐ Dental fear/anxiety	☐ Prolonged bleeding
☐ Prosthetic implants	☐ Psychiatric care	☐ Swollen ankles
☐ Repeated sore throats/colds	☐ ENT	☐ Tonsils removed
☐ Adenoids removed	☐ Latex allergy	☐ Nickel allergy

☐ Asthma, hay fever, allergies, specify____

Heart condition? ☐ No ☐ Yes Pre-medication required? Medication: ____________________

I fully understand the open concept in orthodontics and have no problem being treated in this area.
To the best of my knowledge the above information is correct.

Patient/Guardian Signature:_________________________________ Date: ___________________