PATIENT REGISTRATION FORM (Please Print Clearly)

Welcome to Lansdowne Orthodontics!

Federal and state laws require us to obtain the following confidential information with 2 forms of <u>identification</u>. Also, to give you the best consideration of your orthodontic needs and to thoroughly diagnose any condition, we must have accurate background and health information.

			th date Sex M
			Zip
Prim. Phone ()_	H_W(C_ Alter. Phone () H_ W_ C_
Family Dentist	Ph#	_ Family Physician	
Referred by	Email(app	ot. notification)	
Primary Person Responsi	ble for Account		Relationship
			urity Number
	rent from pt)		
Employer Name & Addre			
Medical Insurance Carri	er:	ID#	Group#
			<i>G</i> roup#
Secondary Person Responsate of Birth	onsible for Account	Social Securit	y Number
			,
	rent from pt)		
Home Address (if differ			
Home Address (if differ	rent from pt)		
Home Address (if differ Email Employer Name & Ad	rent from pt)		
Home Address (if differ Email Employer Name & Ad Medical Isurance Carrie	dress	ID #	
Home Address (if differ Email Employer Name & Ad Medical Isurance Carrie Dental Insurance Carrie	dress	ID #	Group #
Home Address (if differ Email	dress r:AMILY HISTORY - Patient live	ID # ID # es with Mother's Name	Group # Group # Relationship to pt
Home Address (if differ Email	dress r:AMILY HISTORY - Patient live	ID # ID # es with Mother's Name	Group # Group # Relationship to pt
Home Address (if differ Email	dress r:AMILY HISTORY - Patient live	ID # ID # es with Mother's Name Parent's Marital S	Group # Group # Relationship to pt
Home Address (if differ Email	dress r: AMILY HISTORY - Patient live e# of Sisters#	ID # ID # es with Mother's Name Parent's Marital S	Group # Group # Relationship to pt
Home Address (if differ Email Employer Name & Ad Medical Isurance Carrie Dental Insurance Carrie MINOR PATIENTS'S FA If a minor: Father's Name Siblings: None # of B	dressr:	ID # ID # es with Mother's Name Parent's Marital Si	Group # Group # Relationship to pt tatus
Home Address (if differ Email Employer Name & Ad Medical Isurance Carrie Dental Insurance Carrie MINOR PATIENTS'S FA If a minor: Father's Name Siblings: None # of B PATIENT'S MEDICAL _ Asthma _ Anemia	dress er: AMILY HISTORY - Patient live Erothers # of Sisters HISTORY - Has patient eve _ Diabetes _ Epilepsy	ID # ID # es with Mother's Name Parent's Marital State ar had: Heart Disease	Group # Group # Group # Relationship to pt tatus Hepatitis
Home Address (if differ Email Employer Name & Ad Medical Isurance Carrie Dental Insurance Carrie MINOR PATIENTS'S FA If a minor: Father's Name Siblings: None # of B PATIENT'S MEDICAL _ Asthma	dress er: AMILY HISTORY - Patient live Erothers # of Sisters HISTORY - Has patient eve _ Diabetes _ Epilepsy	ID # ID # es withMother's Name Parent's Marital Si er had: Heart Disease Hearing Disease	Group # Group # Relationship to pt tatus Hepatitis Rheumatic Fever

Present dr Birth Defe	rugs or medication: ects:							
	atient reached pubert	y (menstruation, p	oubic hair)	Yes	No			
•	TORY HISTORY - Doe	•						
1. Ho	ave allergies to:	Seasonal grasse	S	F	ood			
	J	Drugs			ther			
2. Sr	nore while sleeping?				Yes	No		
	outh Breather?				Yes	No		
4. Ho	ave frequent colds?				Yes	No		
5. Ho	5. Have frequent stuffy nose?					No		
	6. Have frequent sore throat or tonsillitis?					No		
	ave chewing or swallo		Yes	No				
DENTAL F	HISTORY							
Does the patient have pain or clicking in jaw joint?					Yes	No		
Have any teeth been injured due to accidents or blows to the mouth?					Yes	No		
•	.jury:							
	atient received or re		ve speech corr	ection?	Yes	No		
	ving habits are of int				is patien	† :		
Th	numb or Finger suckir	ng? Yes No	Grinding of t	eeth?	Yes	No		
•	p Biting or sucking? thers (specify):		•	st?	Yes	No		
Has the p	patient had any unus	ual dental expe	riences?					
Date of la	ecify: .st dental checkup: _	Were t	he patient's te	eth cleaned	d? Ye:	s No		
ORTHODO	ONTIC HISTORY							
Has the patient had a previous Orthodontic consultation?					Yes	No		
Has the patient had previous Orthodontic treatment?					Yes	No		
Date: Orthodont	Doc tic consultation prom	:tor: pted by? Patien	t Dentist	Mother	Father	Spouse		
	Physician Friend							
² atient's ir	nterest in orthodont	ic treatment:						
	out starting treatme		out treatment	Agains	t having t	treatment		
	e primary concern?				,			
	pected from orthodo	ntic treatment?						
	comments you wish t							
Signature (of individual complete	ing this form:						
Signature of individual completing this form:								
Relationship to patient Too				l'oday	s Date:	day's Date:		

^{*} Insurance carriers require all pertinent information to determine primary and/or secondary insurance coverage. All parties must consent or benefits cannot be accessed. Coverage is employer specific.