CHILD REGISTRATION AND HEALTH HISTORY FORM

Success Orthodontics®

Patient's name_____ Social Security# _____

Nickname_____ Age_____ Sex _____ Birthdate _____

Address _____ City/Zip _____ Years at above address _____

Father's name _____ Occupation _____

Employer _____ Years with employer _____ Business phone _____

Mother's name _____ Occupation _____

Employer _____ Years with employer _____ Business phone _____

Home phone _____ Cell phone _____ (Mother Father)

Whenever possible, we try to give a courtesy (confirmation) call before your appointments. Which number would you like us to use? Preferred email contact _____ (Mother Father)

Parent's marital status: Single Married Widowed Separated Divorced

Person financially responsible for this account _____

If there is orthodontic insurance, insured's Social Security number _____ Date of birth _____

Whom do we contact in case of an emergency? (Other than parent?)

Name _____ Telephone _____

Father's/Mother's address if different from patient _____

Brother's/Sister's names and birthdates _____

Has anyone in the family had orthodontic care? (who?) _____

Is the patient adopted? _____ If "Yes", does the patient know? _____

Patient's physician _____ Telephone _____

Patient's dentist _____ Date of last dental cleaning _____

What are the patient's hobbies and sports? _____

Patient's school _____ Grade _____ Musical instruments played _____

Whom may we thank for referring you to our office? _____

Do you have any friends or relatives who come to our office? _____

Who noticed the orthodontic problem? Patient Parent Dentist Other _____

Describe the orthodontic concern in your own words. _____

What concerns you most about the thought of orthodontic treatment?

☐ Appearance in appliances	Discomfort	Quality of treatment	Low down payment
Cost	Results	Latest technology	Low monthly payment
Length of treatment	Comfort	Clear technology	

I understand that appropriate credit bureau reports may be obtained.
Medical inquiries do not affect your credit score.

Signature (Patient's signature, if minor) _____ Date _____

Patient's name _____ Height _____ Weight _____

AN EXPLANATION

It is our desire to offer the finest treatment for you and/or your child. In order to plan the best treatment, it is important that we understand the medical/dental background of our patients. While some of the questions may seem personal, the answers may be very important to our planned orthodontic treatment. Thank you for your cooperation.

Is the patient under the care of a physician? (who and why?) ..... ☐ yes ☐ no

Does the patient have a health problem now? (what?) ..... ☐ yes ☐ no

Is the patient presently taking any medications? (what?) ..... ☐ yes ☐ no

Are antibiotics necessary for dental procedures? (what?) ..... ☐ yes ☐ no

Does patient have learning disabilities or needs extra help with instructions? ..... ☐ yes ☐ no

Does the patient have any allergies? (what?) ..... ☐ yes ☐ no

Have the tonsils and/or adenoids been removed? (what and when?) ..... ☐ yes ☐ no

Is there a history of ear infection, sore throats, or frequent colds? (which and how frequent?) ..... ☐ yes ☐ no

Has the patient been hospitalized in the past three years? (diagnosed condition?) ..... ☐ yes ☐ no

Does the patient have any mental or physical disability? (what) ..... ☐ yes ☐ no

Is there a history of injury to face, head, or teeth? (what and when?) ..... ☐ yes ☐ no

Does the patient have problems or pain in the jaw joint? (TMJ?) ..... ☐ yes ☐ no

Teeth grinding, jaw clenching, or any clicking, locking in jaw? ..... ☐ yes ☐ no

Does the patient have bleeding gums, gum problems, or history of periodontal (gum) treatment? ..... ☐ yes ☐ no

Is there a history of mouth breathing/snoring or difficulty breathing? (reasons?) ..... ☐ yes ☐ no

Is there a history of finger or thumb sucking? (until what age?) ..... ☐ yes ☐ no

What are the chief concerns you have related to the position of your child's teeth or bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability ☐ Other: _____

Does the patient chew or smoke tobacco? ☐ yes ☐ no Any history of a substance abuse problem? ☐ yes ☐ no

Girls only: Started her monthly period? (when?) ☐ yes ☐ no Is the patient pregnant? ☐ yes ☐ no

Boys: Has his voice changed? (when?) ☐ yes ☐ no

Has the patient ever had any of the following:

AIDS or HIV Positive	☐ yes ☐ no	Cytomegalovirus	☐ yes ☐ no	Measles/Mumps	☐ yes ☐ no
Allergies (latex, metal, etc.)	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Mononucleosis/Polio	☐ yes ☐ no
Anemia	☐ yes ☐ no	Epilepsy/Seizures	☐ yes ☐ no	Organ Transplant	☐ yes ☐ no
Arthritis/Rheumatoid Condition	☐ yes ☐ no	Heart Murmur	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no
Asthma	☐ yes ☐ no	Cardiovascular/Heart Trouble	☐ yes ☐ no	Psychiatric Treatment	☐ yes ☐ no
Bleeding Disorder	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	Shortness of Breath	☐ yes ☐ no
Cancer Treatment	☐ yes ☐ no	Herpes (any type)	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no
Canker Sores	☐ yes ☐ no	High or Low Blood Pressure	☐ yes ☐ no	Stroke	☐ yes ☐ no
Chicken Pox	☐ yes ☐ no	Endocrine/Thyroid Problems	☐ yes ☐ no	Swelling of Ankles	☐ yes ☐ no
Chronic Cough	☐ yes ☐ no	Jaundice/Liver Problems	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Congenital Heart Lesion	☐ yes ☐ no	Kidney Problems	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no

I hereby certify that I have read and understand the above questions and that the information provided is accurate to the best of my knowledge. I will not hold Dr. Gen or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history later, I will inform this practice. I also consent to the making of diagnostic records, including x-rays before, during, and following orthodontic treatment.

Parent's signature _____ Doctor's signature _____ Date _____

PEDIATRIC SLEEP QUESTIONNAIRE

Patients under 18 years of age

Success Orthodontics®

Last Name _____ First Name _____ Age _____ Date_____

Please answer on behalf of your child for the past month. If you don't know, please circle "?"

WHILE SLEEPING, DOES YOUR CHILD:

Snore more than half the time?	Yes	No	?
Always snore?	Yes	No	?
Snore loudly?	Yes	No	?
Have trouble breathing, or struggle to breathe?	Yes	No	?
Have "heavy" or loud breathing?	Yes	No	?
Have you ever seen your child stop breathing during the night?	Yes	No	?
Have restless or agitated sleep? Grinding teeth?	Yes	No	?
Have abnormal head posture (hyper-extension, etc.)	Yes	No	?

DOES YOUR CHILD:

Tend to breathe through the mouth during the day?	Yes	No	?
Have a dry mouth or waking up in the morning?	Yes	No	?
Occasionally wet the bed?	Yes	No	?
Wake up feeling unrefreshed in the morning?	Yes	No	?
Have a problem with sleepiness during the day?	Yes	No	?
Has a teacher commented that your child appears sleepy during the day?	Yes	No	?
Is it hard to wake your child up in the morning?	Yes	No	?
Does your child wake up with headaches in the morning?	Yes	No	?
Did your child stop growing at a normal rate at any time since birth?	Yes	No	?
Is your child overweight?	Yes	No	?
Frequently sick, has a history of sore throat, ear infections, sinus infections or allergies?	Yes	No	?
Has habits such as pacifier/ thumb sucking/ lip biting/ other?	Yes	No	?

MY CHILD OFTEN:

Does not seem to listen when spoken to directly	Yes	No	?
Has difficulty organizing tasks and activities	Yes	No	?
Is easily distracted by extraneous stimuli	Yes	No	?
Fidgets with hands or feet or squirms in seat	Yes	No	?
Is "on the go" or often acts as if "driven by a motor"	Yes	No	?
Interrupts or intrudes on others (e.g. butts into conversations or games	Yes	No	?