Dr. Traci R. Fernandes – Specialists in Orthodontics

Patient History (Dependent Registration Form)

Patient full/legal name _____ Sex ☐ M ☐ F Age _____

Patient prefers to be called _____ Phone # _____ Birth Date _____

Home Address _____ City _____ ST _____ Zip _____

Mailing Address ☐ Same or list if different _____ Email Address _____

Name of School _____ Grade _____ Patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Parent's Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

Mother/Guardian's Name _____ Birth Date _____ SS # _____

Address _____ City _____ ST _____ Zip _____

Phone Numbers Home # _____ Work # _____ Cell # _____

Father/Guardian's Name _____ Birth Date _____ SS # _____

Address _____ City _____ ST _____ Zip _____

Phone Numbers Home # _____ Work # _____ Cell # _____

In case of emergency contact _____ Phone # _____ Relationship _____

Whom may we thank for referring you? _____

Names of other family members being treated in our office _____

Please list any sports, hobbies or interests _____

Medical History

For the following questions mark "Y" for Yes and "N" for No. The answers are for office record only and are confidential. A thorough and complete history is vital to a proper orthodontic evaluation. **Has the patient ever been diagnosed with:**

Hepatitis ……..	☐ Y	☐ N	Bone Disorders or Osteoporosis…..	☐ Y	☐ N	Endocrine or Thyroid …….....	☐ Y	☐ N
Epilepsy ……..	☐ Y	☐ N	HIV Positive/AIDS …….	☐ Y	☐ N	Fainting or Dizziness …….....	☐ Y	☐ N
Arthritis ……..	☐ Y	☐ N	Allergy/Hay Fever ……..	☐ Y	☐ N	Kidney Involvement ……	☐ Y	☐ N
Anemia ……	☐ Y	☐ N	Rheumatic Fever …….	☐ Y	☐ N	Frequent Headaches ……	☐ Y	☐ N
Asthma …….....	☐ Y	☐ N	Heart Trouble ……..	☐ Y	☐ N	Prolonged Bleeding …….	☐ Y	☐ N
Herpes …….	☐ Y	☐ N	Tuberculosis ……	☐ Y	☐ N	Nervous Disorders ……..	☐ Y	☐ N
Cancer …….	☐ Y	☐ N	Diabetes ……...	☐ Y	☐ N	Liver Involvement ……..	☐ Y	☐ N

Is the patient in good health? …….. ☐ Y ☐ N If no, please explain _____

Has the patient seen a physician in the last 2 years? …….. ☐ Y ☐ N If yes, please explain _____

History of major illness/congenital disorder? ☐ Y ☐ N If yes, please explain _____

Does patient have any behavioral/psychiatric disorders? ☐ Y ☐ N If yes, please explain _____

Any drugs or medications now being taken? …….. ☐ Y ☐ N If yes, please list _____

Any allergies to medications, anesthetics, latex, acrylic, metals or other materials? ……..... ☐ Y ☐ N If yes, please explain _____

Has the patient had adenoids or tonsils removed? …….. ☐ Y ☐ N If yes, at what age? _____

Has the patient ever used Phen-fen? ……..... ☐ Y ☐ N Does the patient smoke or chew tobacco? ☐ Y ☐ N

(For females) Is the patient pregnant? ……..... ☐ Y ☐ N Height….. Patient _____ Mother _____ Father _____

Has the patient begun puberty? ……..... ☐ Y ☐ N If yes, at what age? _____

Is the patient currently or previously taken ☐ Fosamax ☐ Actonel ☐ Boniva ☐ Skelid ☐ Didronel ☐ Aredia ☐ Zometa ☐ None

Name of Physician _____ City _____ Phone # _____

Dental History

Has the patient ever sucked a thumb/finger? ☐ Y ☐ N If yes, until what age _____

Does the patient clench or grind their teeth? ☐ Y ☐ N If yes, please explain _____

Does the patient have speech problems? ☐ Y ☐ N If yes, please explain _____

Is the patient apprehensive toward dental visits? ☐ Y ☐ N If yes, please explain _____

Has the patient had previous orthodontic examinations? ☐ Y ☐ N If yes, when _____ Was treatment provided? ☐ Y ☐ N

Have there ever been injuries to the face, mouth or teeth? ☐ Y ☐ N If yes, please explain _____

Does the patient predominantly breathe through their nose? ☐ Y ☐ N _____

Has the patient been informed of missing or extra permanent teeth? ☐ Y ☐ N _____

Has the parent or other children had orthodontic treatment? ☐ Y ☐ N _____

Has the patient had any clicking/discomfort in the jaw joints near the ears? ☐ Y ☐ N _____

What is your or dentist's orthodontic concern? _____

Date of last dental examination _____ Were X-rays taken? ☐ Y ☐ N

Name of Dentist _____ City _____ Phone # _____