Andrew Trosien, DDS, MS, Inc
Specialist in Orthodontics

PATIENT REGISTRATION

Thank you for completing the information below. Your information in this history form will help us to provide the best care and service for you.

Whom may we thank for referring you? _____ TODAY'S DATE:_____

PATIENT NAME**:** _____ NICKNAME : _____

HOME ADDRESS: _____

PATIENT'S AGE: _____ GENDER: _____ DATE OF BIRTH: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

text reminders? Yes / No email reminders? Yes / No

SCHOOL: _____ GRADE: _____

FATHER'S NAME _____ DOB _____

MOTHER'S NAME _____ DOB _____

SIBLING NAME _____ DOB _____

SIBLING NAME _____ DOB _____

MEDICAL HISTORY

PHYSICIAN'S NAME:_____

ADDRESS:_____

PHONE:_____ DATE OF LAST VISIT:_____/_____/_____

Yes No

- ☐ ☐ Has patient undergone a physical exam in the past year?
- ☐ ☐ Is the patient currently under a physician's care?
- ☐ ☐ Has the patient had a major surgery? For what?_____
- ☐ ☐ Has the patient ever been hospitalized? For what?_____
- ☐ ☐ What medications is the patient taking?_____
- ☐ ☐ Is patient allergic to penicillin?
- ☐ ☐ What medication(s) is the patient allergic to?_____
- ☐ ☐ Has patient had ☐tonsils and/or ☐adenoids removed?
- ☐ ☐ Does patient have fainting or dizzy spells?
- ☐ ☐ Does patient have too high or too low blood pressure?
- ☐ ☐ Has patient been diagnosed or treated for the following?

☐ Heart problems	☐ Hepatitis
☐ Kidney problems	☐ Rheumatic fever
☐ Lung problems	☐ Emotional problems
☐ Liver problems	☐ Malignancies
☐ Allergies	☐ Endocrine problems
☐ Diabetes	☐ Bone
☐ Epilepsy	☐ Prolonged bleeding
☐ Anemia	☐ Tuberculosis
☐ Arthritis	☐ Asthma

DENTAL HISTORY

DENTIST'S NAME: _____

ADDRESS: _____

PHONE: _____ DATE OF LAST VISIT:_____/_____/_____

What is the major concern about the patient's teeth?

_____

_____

_____

Yes No

- ☐ ☐ Has patient had previous orthodontic consultation/treatment?
- ☐ ☐ Has patient been informed of any extra or missing teeth?
- ☐ ☐ Have any permanent teeth been removed by extraction?
- ☐ ☐ Has any family member had orthodontic treatment?
  Who?_____
- ☐ ☐ Does patient now suck his/her thumb or finger?
- ☐ ☐ Does patient breathe predominantly through the mouth?
- ☐ ☐ Does patient have any speech problems?
- ☐ ☐ Does patient grind or clench his/her teeth?
- ☐ ☐ Have any teeth been injured or chipped due to an accident?
- ☐ ☐ Has patient ever had severe jaw or head injury?
- ☐ ☐ Do patient's gums bleed on brushing or flossing?
- ☐ ☐ Is patient concerned about appearance of his/her teeth?
- ☐ ☐ Does patient want his/her teeth straightened?
- ☐ ☐ Are there any other medical or dental problems I should be aware of?

_____

EMERGENCY INFORMATION: Name of nearest relative not living with you:_____

Address:_____ Phone #_____

PRINT NAME OF PERSON SIGNING HEALTH HISTORY_____

SIGNATURE_____ (parent's signature if minor) DATE _____/_____/_____

MINOR PATIENTS

Patient Name:_____ Date_____

At Dr. Trosien's, we understand that children may come from families where both parents live separate lives, apart from one another. Although it's best when both parents are in full agreement about the dental health of their child and the financial responsibility associated with that, we understand that it not always the case. Along with you, our goal is to make this experience as pleasant as possible for everyone. To help with that, it is best to establish a clear understanding of each of the parental roles with regards to any legal decisions, consent for treatment and financial responsibilities. Please provide our office the answers to the following questions so that all parties are aware of the agreement.

Please check one that applies:

____Patient is a minor living with **both natural parents**

____Patient is a minor living with **one custodial parent** _____
(both parents **share legal** decisions) *Custodial Parent's Name (Print)*

____Patient is a minor living with **one custodial parent** _____
(**Custodial parent ONLY** has sole custodianship) *Custodial Parent's Name (Print)*
(**court order is required** on file with Orthodontist)

____Patient is a minor **living equally between both** parent's homes
(**parents share** equally in legal decisions)

____Patient is a minor living with **grandparent** _____
(grandparent does **NOT** have legal guardianship) *Grandparent's Name (Print)*

_____
Name of legal guardian (Print)

____Patient is a minor living with **grandparent** _____
(grandparent **HAS** legal guardianship, **court order is required**) *Grandparent's Name (Print)*

____Patient is a minor living with **someone other than parent** or grandparent

_____
(Print) Custodial Person's Name (person child is living with)

_____
(Print) Legal/Financial Person's Name

CONSENT of treatment will be given by _____
Parent or legal Guardian (Print)

_____
Signature

FINANCIAL RESPONSIBILITY

Patient Name_____ Date_____

Note: If both parents have joint custody, the consent of one parent generally is sufficient to proceed with treatment. If both parents want to provide consent, we will require both parents to be present at the time information on proposed treatment is provided. Both parents, regardless of custody arrangement, have the right to view or to request a copy of a child's treatment record unless a custodial agreement or a court order states otherwise. (This does not include financial records if only one parent is financially responsible)

Is there more than one financially responsible person signing the financial agreement? Y / N
If yes, is there a need to have separate financial agreements for each parent? Y /N

Note: *If yes, both parents must understand that if default occurs on either agreement, treatment may be compromised, regardless of which parent has defaulted.*

There IS____ IS NOT____ a court order establishing financial responsibility for treatment (If there is a court order, copy is required)

1)_____ _____
*Name of **Financially Responsible Person*** *Relationship to Patient*

Address _____
Phone Number (_____) _____

2)_____ _____
*Name of **Financially Responsible Person*** *Relationship to Patient*

Address _____
Phone Number (_____) _____

INSURANCE

Patient Name_____Date_____

Note: If the patient is covered by two or more insurance plans, industry rules dictate the plans are billed in the following order:

1) *The plan of the parent with custody of the patient. If parents have joint legal custody, the plan of the parent whose birthday is first in the calendar year is primary. If both parents have the same birth month, the plan that has been in effect the longest is the primary plan.*
2) *If only one parent has custody and that parent has remarried, the plan of that parent's spouse provides secondary coverage.*
3) *The plan of the noncustodial parent is third.*
4) *The plan of the noncustodial parent's spouse is fourth.*

Note: Billing a parent's insurance does NOT give access to the financial records if he/she is not a financially responsible parent as named on the Financial Responsibility Form.

1)_____ _____
*Name of **Person Providing Insurance** (Print)* *Relationship to Patient*

SS or ID#_____ DOB _____
Employer_____
Insurance Carrier_____
Billing Address_____

2)_____ _____
*Name of **Person Providing Insurance** (Print)* *Relationship to Patient*

SS or ID#_____ DOB _____
Employer_____
Insurance Carrier_____
Billing Address _____

3)_____ _____
*Name of **Person Providing Insurance** (Print)* *Relationship to Parent*

SS or ID#_____ DOB_____
Employer_____
Insurance Carrier_____
Billing Address_____