



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

SPOUSE'S NAME (if married) _____ DOB _____

CHILD'S NAME: _____ DOB _____

CHILD'S NAME: _____ DOB _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____

ADDRESS: _____

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

DENTAL HISTORY

DENTIST'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

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 _____ DATE ____/____/____

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 _____