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Specialist in Orthodontics
For
Adult and Children

OFFICE LOCATIONS:
BAY MINETTE

EASTERN SHORE

FOLEY

REGISTRATION HISTORY CHILD/ADOLESCENT

CHILD'S NAME _____ DATE _____

BIRTHDATE _____ AGE _____ SCHOOL _____ GRADE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DO YOU HAVE ANY FRIENDS/RELATIVES THAT ARE OR HAVE BEEN PATIENTS HERE? _____

*FATHER/GUARDIAN NAME _____

PHONE (home) _____ (cell) _____ EMAIL _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

EMPLOYED BY _____ POSITON _____

BUSINESS ADDRESS _____ PHONE _____

*MOTHER/GUARDIAN NAME _____

PHONE (home) _____ (cell) _____ EMAIL _____

MAILING ADDRESS _____

PHYSICAL ADDRESS _____

EMPLOYED BY _____ POSITON _____

BUSINESS ADDRESS _____ PHONE _____

ARE PARENTS DIVORCED/SEPARATED _____ CHILD LIVES WITH _____

WHO WILL USUALLY BRING PATIENT IN FOR APPOINTMENTS _____

WHO WILL PAY THIS ACCOUNT _____

IN CASE OF EMERGENCY _____ PHONE _____

NAME OF PHYSICIAN _____ PHONE _____

DATE OF LAST HEALTH EXAMINATION _____ FOR WHAT _____

HAS CHILD BEEN HOSPITALIZED IN LAST 5 YEARS? _____ FOR WHAT? _____

<u>HAS CHILD EVER HAD?</u>	YES	NO		YES	NO
ANEMIA	___/___		TONSILS/ADENOIDS OUT	___/___	
DIABETES	___/___		EPILEPSY	___/___	
GROWTH DISORDER	___/___		RHEUMATIC FEVER	___/___	
BONE PROBLEMS	___/___		ABN BLOOD PRESSURE	___/___	
HEPATITIS	___/___		ASTHMA	___/___	
CHICKEN POX	___/___		HEART PROBLEMS (MURMER)	___/___	

IF ALLERGIES TO MEDICATIONS INDICATE WHICH ONES _____

IS CHILD ON ANY MEDICATION _____ FOR WHAT? _____

OTHER PHYSICAL, PSYCHOLOGICAL, EMOTIONAL CONDITIONS? _____

HAVE THERE BEEN INJURIES TO FACE, MOUTH, TEETH OR SCARS? **YES/NO**

HAS THE PATIENT EVER SUCKED A THUMB/FINGER (UNTIL WHAT AGE?) **YES/NO**

HAD CLICKING/POPPING/PAIN/GRINDING/CLENCHING TEETH WHEN CLOSING MOUTH **YES/NO**

BEEN INFORMED OF MISSING PERMANENT TEETH **YES/NO** EXTRA PERMANENT TEETH **YES/NO**

HAD ANY FAMILY MEMBER WITH SIMILAR DENTAL/ORTHO CONDITIONS? **YES/NO**

DID THEY HAVE ORTHODONTIC TREATMENT? **YES/NO**

DOES PATIENT DESIRE TREATMENT? **YES/NO**

HAD ANY APPLIANCES PLACED TO MAINTAIN SPACE? **YES/NO**

IS PATIENT ADOPTED OR FOSTER? **YES/NO**

ARE YOU AWARE THAT SOME APPOINTMENTS WILL INFRINGE ON SCHOOL TIME? WORK? **YES/NO**

CONSULTED AN ORTHODONTIST PREVIOUSLY **YES/NO**

WHO FIRST NOTICED NEED FOR ORTHODONTIC? DENTIST___ PARENT___ PATIENT___

GENERAL DENTIST _____

PURPOSE OF THIS APPOINTMENT _____

NAME AND AGES OF OTHER CHILDREN IN FAMILY _____

IF TREATMENT IS NECESSARY, HOW SOON WOULD YOU PREFER TO BEGIN _____

ARE YOU INTERESTED IN CLEAR OR INVISIBLE BRACES? _____