H. L. STRICKLAND, JR., D.D.S., P.A.

Specialist In Orthodontics
For
Adults And Children

Date________________________

OFFICE LOCATIONS:
EASTERN SHORE **BAY MINETTE** **FOLEY** **GULF SHORES**

REGISTRATION HISTORY CHILD/ADOLESCENT

CHILD'S NAME ____

AGE __________ SCHOOL ______________________________ GRADE __________

CHILD'S INTERESTS/HOBBIES ______________________________

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

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

____

____

FATHER'S NAME ______________________________ HOME PHONE ______________

MAILING ADDRESS ____________________ CITY __________ STATE ________ ZIP ________

LOCATION ADDRESS ____________________ CITY __________ STATE ________ ZIP ________

EMPLOYED BY: ______________________________ POSITION ______________

BUSINESS ADDRESS ______________________________ PHONE ______________

MOTHER'S NAME ______________________________ HOME PHONE ______________

MAILING ADDRESS ____________________ CITY __________ STATE ________ ZIP ________

LOCATION ADDRESS ____________________ CITY __________ STATE ________ ZIP ________
(If different from fathers)

EMPLOYED BY ______________________________ POSITION ______________

BUSINESS ADDRESS ______________________________ PHONE ______________

IN CASE OF EMERGENCY WHOM SHOULD BE NOTIFIED ____________________ PHONE ______________

ARE PARENTS DIVORCED OR SEPARATED? ______________

WHO WILL USUALLY BRING PATIENT IN FOR APPOINTMENTS? ______________________________

WHO WILL PAY THIS ACCOUNT? ______________________________

____

RESPONSIBLE PARTY E-MAIL ADDRESS ______________________________
PATIENT'S E-MAIL ADDRESS ______________________________
CELL PHONE CONTACT NUMBER ______________________________

DO YOU HAVE ORTHODONTIC INSURANCE THAT MAY REIMBURSE YOU FOR ANY PART OF OUR PROFESSIONAL SERVICES? YES ________ NO ________

NAME OF INSURANCE COMPANY ________________________________

MAXIMUM LIMITS OF YOUR ORTHODONTIC COVERAGE ________________________________

NAME OF PHYSICIAN ________________________________

ADDRESS ________________________________

MAY WE REQUEST YOUR CHILD'S HEALTH RECORDS IF NECESSARY? YES ________ NO ________

BIRTHDATE ________________ DATE OF LAST HEALTH EXAMINATION ________________

FOR WHAT ________________________________

HAS CHILD BEEN HOSPITALIZED IN LAST 5 YEARS? ________ FOR WHAT? ________________

____

HAS CHILD EVER HAD:

	YES	NO		YES	NO
ANEMIA			TONSILS/ADENOIDS OUT		
DIABETES			EPILEPSY		
GROWTH DISORDER			RHEUMATIC FEVER		
BONE PROBLEMS			ABNORMAL BLOOD PRESSURE		
HEART PROBLEMS			HEPATITIS		
HEART MURMER			CHICKEN POX		
ALLERGIES TO MEDICATIONS					
ASTHMA					

IF ALLERGIES TO MEDICATIONS INDICATE WHICH ONES ________________________________

____

IS CHILD ON ANY MEDICATION ________ FOR WHAT? ________________________________

OTHER PHYSICAL, PSYCHOLOGICAL, EMOTIONAL CONDITIONS ________________________________

____

PURPOSE OF THIS APPOINTMENT ________________________________

NAMES AND AGES OF OTHER CHILDREN IN FAMILY ________________________________

HAVE ANY BEEN PATIENTS HERE? ________________________________

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

ARE YOU INTERESTED IN CLEAR OR INVISIBLE BRACES? ________________________________