

**PATIENT REGISTRATION & MEDICAL HISTORY**

Please answer ALL questions to the best of your knowledge. The information requested below is very important. Please make it as complete and accurate as possible, as it will help us to provide the best possible health service. This information form becomes part of our permanent records and will be held in *strict confidence*. For patients of parents, complete this information for your child. Please circle YES or NO when applicable. *Please update your medical history every 6 months.* Thank you.

**PERSONAL**

Patient Name: \_\_\_\_\_  
 Nickname or Preferred Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_  
 Mobile Phone #: \_\_\_\_\_  
 Patient's Email Address: \_\_\_\_\_  
 Ethnic Background: (check all that apply, for diagnostic purposes only)  
 Filipino       Caucasian       African American  
 Hispanic       Asian (please specify): \_\_\_\_\_  
 Other: \_\_\_\_\_  
 Gender:  Male  Female  
 Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs.

**BILLING PARTY & FAMILY**

Billing Party Name: \_\_\_\_\_  
 Relationship to patient:  Mother  Father  
 Other \_\_\_\_\_  
 Billing Party Address (if different from patient's):  
 Street: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_  
 Mobile Phone #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Work Phone #: \_\_\_\_\_  
 Mobile Phone #: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

Parent primarily responsible for scheduling, bringing patient to appointment, etc:  
 Mother  Father  Both  Other \_\_\_\_\_

Please provide the names and ages of any siblings:

Name	Age

**DENTAL**

1. \*Please describe the orthodontic problem you would like to see corrected: \_\_\_\_\_  
 \_\_\_\_\_  
 2. Does anyone in the family have a similar dental or facial condition? YES NO \_\_\_\_\_  
 3. Who referred you to our office? \_\_\_\_\_  
 4. Name of family dentist: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 5. Date of last dental appointment: \_\_\_\_\_  
 6. How frequently does patient brush? \_\_\_\_\_  
 Floss? \_\_\_\_\_  
 7. Have the patient's teeth ever been injured? YES NO  
 Please describe: \_\_\_\_\_  
 8. Please check if the patient has or ever had any of the following habits:  
 Grinding / Clenching       Lip biting / sucking  
 Nail biting       Tongue thrusting  
 Thumb/ finger sucking       Mouth breathing  
 9. Rate parent's concern for correction of the orthodontic problem:  
 Very concerned       Concerned  
 Indifferent       Opposed  
 Uncertain  
 10. Rate patient's concern for correction of the orthodontic problem:  
 Very concerned       Concerned  
 Indifferent       Opposed  
 Uncertain  
 11. How do you think the patient will react to orthodontic treatment?  
 Excellent       Good  
 Fair       Poor  
 Uncertain  
 12. Has the patient ever had a consultation for orthodontic treatment before? YES NO  
 13. Has the patient ever had braces / orthodontic appliances? YES NO If YES, when? \_\_\_\_\_

**SOCIAL**

1. Name of school: \_\_\_\_\_  
 2. Address of school: \_\_\_\_\_  
 3. Grade/Year in school: \_\_\_\_\_  
 4. Please check all that apply to the patient:  
 Calm       Defiant       Cooperative  
 Shy       Fearful       Moody  
 Healthy       Sickly       Talkative  
 Active       Curious       Friendly  
 Temper tantrums  
 5. Please list any hobbies, interests, special interests, pets, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICAL**

- Name of physician: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_
- Date of patient's last physical exam: \_\_\_\_\_
- Please check if the patient is currently taking any of the following medications:  
 Antibiotics                       Cortisone, Other Steroids  
 Anticoagulants                       Insulin  
 Anticonvulsants                       Aspirin  
 Antipsychotics                       Other: \_\_\_\_\_
- Is there a past history of the patient taking any of the above medications? YES NO  
If yes, please describe: \_\_\_\_\_
- Please list any allergies, including latex and/or drug allergies: \_\_\_\_\_
- Please check if the patient has had any unfavorable reactions to the following:  
 Local Anesthetics                       Antibiotics  
 Aspirin                       Sulfa Drugs  
 Other: \_\_\_\_\_
- Please check if the patient has a history of:  
 Autism or any intellectual, behavioral, or emotional difficulties. Please describe: \_\_\_\_\_

**MEDICAL (cont'd)**

- Please check if patient has a history of the following:  
 Anemia                       Heart problems  
 Asthma / emphysema / breathing problems                       Hepatitis / jaundice / liver disease  
 Arthritis                       High blood pressure  
 Autism                       Kidney disease  
 Bone or joint problems                       Mitral valve prolapse  
 Brain injury                       Persistent cough / coughing blood  
 Cancer: \_\_\_\_\_                       Psychiatric problems  
 Cerebral palsy                       Rheumatic fever or heart disease  
 Diabetes                       Sickle cell anemia  
 Emotional difficulties                       Speech difficulties  
 Epilepsy / seizures                       Stomach ulcer  
 Excessive bleeding                       Thyroid disease  
 Fainting or dizziness                       Tuberculosis  
 Hearing difficulties                       OTHER: \_\_\_\_\_  
 HIV+ / AIDS
- Please check if there is a family history of the following:  
 Birth defects                       Liver disease  
 Bleeding disorder                       Lupus  
 Cancer: \_\_\_\_\_                       Obesity  
 Diabetes                       Rheumatoid arthritis  
 Heart disease                       Sickle cell anemia  
 Hypertension                       Tuberculosis  
 Kidney disease                       Other: \_\_\_\_\_
- Does the patient require antibiotics before certain dental treatments? YES NO
- FOR FEMALE PATIENTS ONLY: At what age did menarche (menstruation) begin? \_\_\_\_\_ years

**CONSENT STATEMENT**

Dr. Elaine V. Sunga and her staff are hereby authorized to perform such dental and related surgical or medical treatments as deemed necessary to adequately provide such treatment for the above named patient.

The undersigned understands and agrees that each patient's records and materials pertinent to his/her treatment become property of Dr. Elaine V. Sunga – Orthodontics & Dentofacial Orthopedics. Dr. Elaine V. Sunga and staff are authorized to furnish, from the patient's record, requested information of pertinent nature or excerpts thereof, to any approximate insurance company for the purpose of obtaining payment of the account of the patient. By signing, I also give my permission for the use of orthodontic records made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals by Dr. Elaine V. Sunga.

***I have read the preceding information fully, and understand it, and agree to comply with all rules and regulations for patient processing and treatment. To the best of my knowledge, the preceding answers are complete and accurate.***

\_\_\_\_\_  
Signature of Parent / Guardian or Person Authorized to Consent for Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY:**

**Health history reviewed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

**Health History Updates: (every 6 months while in active treatment)**

Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____
Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____

Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____
Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____