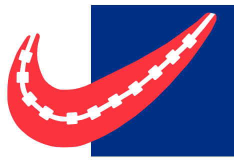

REICHL & KOLSTAD ORTHODONTICS

Specialists in Orthodontics and Dentofacial Orthopedics

CHILD REGISTRATION FORM

Patient's Last Name: ______________________________ **First Name**: ______________________ **Nickname**: ____________

Birth Date ____________________ Gender: M F School: __________________________________ Grade: __________

Patient's Address: ____

City: ____ State: ___________ Zip Code: ________________

Home Phone: _____________________________

How were you referred to our office? Dentist: ____________________________ Friend: ____________________________

Ad: __________________ Mail Flyer: __________________ School Tour: __________________ Internet: __________________

Financially Responsible Party: ____ **Child lives with:** ____________________

Parents are: Married Separated Single Widowed Divorced Domestic Partner

Father's Name: ____ Birth Date: ___________________________

Address (*if different than patient's*): ____

Cell Phone: ______________________ Work Phone: ____________________ Email: _______________________________

Employer: ____ Occupation: __________________________

Mother's Name: ____ Birth Date: ___________________________

Address (*if different than patient's*): ____

Cell Phone: ______________________ Work Phone: ____________________ Email: _______________________________

Employer: ____ Occupation: __________________________

Guardian's Name: ____ Birth Date: ___________________________

Address (*if different than patient's*): ____

Cell Phone: ______________________ Work Phone: ____________________ Email: _______________________________

Employer: ____ Occupation: __________________________

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: ______________________________________

Insurance Company: ________________________________

Group #: ____

ID#: ____

Address: ____

Phone # on Ins. Card: _______________________________

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder: ______________________________________

Insurance Company: ________________________________

Group #: ____

ID#: ____

Address: ____

Phone # on Ins. Card: _______________________________

OVER

MEDICAL HISTORY	
Name of Physician:	Describe if you are currently under medical care:
List any medications now being taken:	
List any allergies:	

PLEASE CHECK ANY OF THE FOLLOWING THE PATIENT HAS OR HAS HAD:

	Premedication for Dental Treatment		Diabetes		Ear Problems
	Prosthetic Cardiac Valve		Osteoporosis/Bone Disorder		Sinus Problems
	Previous Infective Endocarditis		Epilepsy/Seizures/Fainting/Dizziness		Tonsils/Adenoids Removed
	Unrepaired Cyanotic Congenital Heart Disease		Kidney or Liver Problems		Autism
	Repaired Congenital Heart Defect		Hepatitis		ADHD
	Cardiac Transplantation		Tuberculosis (TB)		Developmental Problems
	Tumors, Radiation, or Chemotherapy		HIV+/AIDS		Learning Disability
	Anemia or Abnormal Bleeding		History of Tobacco Use		Speech Therapy
	Asthma				
	Use of Bisphosphonate Medication(s) – Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, or Zometa				

Use space below for further explanations:

ORTHODONTIC AND DENTAL HISTORY

Name of General Dentist: ____

List any uncompleted dental treatment: ____

What concerns do you have that prompted this visit? ____

Describe any previous orthodontic treatment or consultations: ____

____

Have other members of your family had orthodontic treatment? ____

PLEASE CHECK ANY OF THE FOLLOWING THE PATIENT HAS OR HAS HAD:

	Clicking/Popping or other TMJ noises		Lip biting		Grinding/clenching of teeth
	Pain in TMJ or facial muscles		Mouth breathing		Tongue thrusting
	Jaw that locks in an open or closed position		Unfavorable reaction to dental care		Snoring
	Prior treatment for TMJ problems		Thumb/finger sucking (until age__________)		Nail biting
	Injury to teeth (list teeth & date of injury):				

To the best of my knowledge, the information on the front and back of this form is complete and accurate. I hereby authorize insurance payment for orthodontic services rendered to be sent directly to Reichl & Kolstad Orthodontics. Any amount not covered by insurance will remain my full responsibility. I authorize taking diagnostic orthodontic records, and release of any dental or medical information necessary to process insurance claims. I understand, where appropriate, credit bureau reports may be obtained.

My signature on this form acknowledges that I understand the ways in which my health information may be used or disclosed by Reichl & Kolstad Orthodontics on their Notice of Privacy Practices Information Sheet.

____ ____________________

Signature of Parent or Guardian Date

Telephone: (262) 547-2827 *2140 West St. Paul Ave., Suite A, Waukesha, WI 53188* *Fax: (262) 547-1269*

ReichlKolstadOrtho.com • *JustSmile@ReichlKolstadOrtho.com*

HARTLAND WAUKESHA MUKWONAGO

Creating a beautiful world... one smile at a time.