Bertha Dieguez-Marino, D.M.D., M.P.H.
Specialist in Orthodontics for Children & Adults

CHILD'S NEW PATIENT REGISTRATION

TODAY'S DATE: _____

Child's Full Name: _____ Nickname: _____ Male/Female (Circle)
Birthdate: _____ Age: _____ SS #: _____ School: _____ Grade: _____
Home Address: _____ City: _____ State: ___ Zip Code: _____
Home #: _____ Childs's Hobbies/Sports: _____
List Brothers/Sisters w/Age: _____

Who is accompanying your child today? (Name) _____ Relation: _____
Do you have legal custody of this child? Y/N (circle)

Whom may we thank for your referral? ___ Phonebook ___ Insurance Co ___ Dentist _____ Friend _____
Website ___ If Internet, what did you Google? _____ Other _____

Parent's Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated

	Mother's Information:	**Father's Information**:
Full Name:		
Address:		
City/St/Zip:		
Home #:		
Cell #:		
Employer:		
Work #:		
SS #:		
DL #:		
E-mail:		

Person(s) Financially Responsible for Acct:
Name(s): _____ Relation to child: _____
Billing Address: _____
City: _____ State: ___ Zip: _____ SS #: _____ DL #: _____
E-Mail: _____ Home #: _____ Cell/Other #: _____
Employer: _____ Work #: _____ Ext: _____

Person responsible for making Appointments:
Name: _____ Work #: _____ Home #: _____ Cell #: _____

Insurance Information:	**Primary:**	**Secondary:**
Ins. Co. Name:		
Phone #:		
Ins. Co. Address:		
Insured's Name:		
Relationship to Patient:		
Insured's Birthday:		
Insured's SS#:		
Insured's Employer:		
Effective Date:		
Contract #:		
Group #:		
Lifetime Max:	Payable @ %:	Payable@%:
Age Limit for Ortho:		
Waiting Period?	Y/N (circle) Period ends:	Y/N (circle) Period ends:

Date:

DENTAL HISTORY:

Dentist Name Last Visit For what service?
Any injuries to the face, mouth, teeth, or chin? Y/N If Yes, describe
Does child have any habits? Y/N If Yes, please circle - thumb/finger sucking, lip sucking/biting, nail biting, mouth breathing, speech problems, clenching/grinding teeth, pacifier, tongue thrust).
Has your child been informed of any missing, or extra teeth? Y/N
Any unhappy dental experiences? Y/N If Yes, describe
Child's general attitude toward dentistry?
Any pain/tenderness in his/her jaw joint (TMJ) or difficulty chewing? Y/N

Does your child brush his/her teeth daily? Y/N Floss his/her teeth daily? Y/N Do you help your child brush/floss? Y/N
Are disclosing tablets used? Y/N Is Fluoride used in any form? Y/N

Has child ever been evaluated or had orthodontic treatment? Y/N (circle) If Yes, please give treatment details:

What are the main concerns that you would like orthodontics to accomplish?

MEDICAL HISTORY:

Child's Physician Address Phone
Date of last physical exam? Is child under care of physician? Y/N If Yes, please describe

Please list ALL drugs that child is currently taking:
Medication Taken for Medication Taken for
Medication Taken for Medication Taken for

Please indicate ALL allergies or reactions to the following:
Y/N Aspirin Y/N Ibuprofen (Motrin, Advil) Y/N Vinyl Y/N Latex
Y/N Acetaminophen (Tylenol) Y/N Metals, specify Y/N Acrylic Y/N Other, specify

Has your child had now or in the past had:
Y/N Birth Defects or hereditary problems ?
Y/N Rheumatoid or arthritic conditions ?
Y/N Kidney problems ?
Y/N Hepatitis, Jaundice or liver problems ?
Y/N Diabetes ?
Y/N ENT problems ? (Tonsil or adenoids)
Y/N Endocrine or thyroid problems ?
Y/N Immune system problems ?
Y/N Cancer, tumor, radiation treatment or chemotherapy ?
Y/N Polio, mononucleosis, tuberculosis or pneumonia ?
Y/N Fainting spells, seizures, epilepsy or neurological problems ?
Y/N Abnormal bleeding, excessive bleeding or bruising, or anemia ?
Y/N Heart Problems ? (murmur, rheumatic fever, heart defect, chest pain, etc)
If so, explain
Y/N Any bone fractures, major accidents or any other problems ?
Y/N Any learning disabilities, handicaps or need extra help with instructions ?
Y/N Any hospitalizations or operations? If so, describe

Y/N Asthma, sinus problems, hay fever or hives ?
Y/N History of eating disorder (anorexia or bulimia) ?
Y/N Stomach ulcers or hyperacidity ?
Y/N Vision, hearing, tasting or speech difficulties ?
Y/N Skin disorders ?
Y/N Mental health or behavioral problems ?
Y/N Does patient chew or smoke tobacco ?
Y/N Is patient pregnant?
Y/N AIDS or HIV positive ?
Y/N High or low blood pressure ?

Acknowledgment: I have read and understand the above registration form. I will not hold Dr. Bertha Dieguez-Marino or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. In addition, I have received a copy of this office's notice of privacy practices.
Consent to undergo Orthodontic Treatment: I hereby consent to the making of diagnostic records, including x-rays, before, during and after orthodontic treatment prescribed by the doctor as well as to the staff and doctor providing the prescribed orthodontic treatment for the above patient. I fully understand all of the risks associated with treatment.
Assignment of benefits: I hereby give permission to bill my insurance company for the services rendered by Dieguez-Marino Orthodontics P.C., and I agree to assist in the processing all claims for benefits. I hereby authorize direct payment of benefits to Dieguez-Marino Orthodontics P.C.
Financial Responsibility: I hereby agree to be responsible for all charges for services rendered to the patient including any non-covered charges. I also agree that if the unpaid account is referred to a collections agency, to pay all costs of collections, including reasonable fees of one-third of the balance due.

Responsible Party/ Relation to child **Responsible Party/ Relation to child** **/** **Date**

SUBMIT