Clearly Buffalo's Best Smiles
Tyska Alexander
ORTHODONTICS

Patient Registration
(Please Print)

PATIENT INFORMATION

Phone _____ Email _____ Date _____

Name of Minor/Child/Self _____ Preferred Name _____

Gender _____ Age _____ Birthdate _____ Sports _____ Hobbies _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____

Whom may we thank for referring you? _____

DENTAL HISTORY

Family/General Dentist _____

Date of last visit to a dentist _____ For what service _____

Prior orthodontic experience with other children in your family _____

	Yes	No		Yes	No
Has child/self complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child/self brush teeth daily?	☐	☐	Any previous injuries to mouth, teeth, or head?	☐	☐
Does child/self use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Any problems with gagging?	☐	☐			

Any mouth habits - thumbsucking, tongue thrusting, grind teeth, mouth breathing, etc.? _____

MEDICAL HISTORY

Minor/Child/Self Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Medical Conditions _____

	Yes	No		
Is Minor/Child/Self under care of physician now?	☐	☐	Medications	_____
Receiving any medication or drugs?	☐	☐		_____
Ever been hospitalized?	☐	☐		_____
Ever had surgery?	☐	☐	Allergies to medications/metals?	_____
Is there excessive bleeding when cut?	☐	☐	Other allergies	_____

Any speech problems? _____

HAS MINOR/CHILD/SELF HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF SO PLEASE CHECK (√)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bleeding Problems	☐ Diabetes	☐ Heart Problems/Murmur	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

RESPONSIBLE PARTY INFORMATION

Father's/Guardian's/Self Name _____

Address (If different from patient's) _____

_____

Cell Phone _____ Home/Work _____

Employer _____

Soc.Sec.# _____ Birthdate _____

Do you have dental insurance coverage for minor/child/self? ☐ Yes ☐ No

Mother's/Guardian's Name _____

Address (If different from patient's) _____

_____

Cell Phone _____ Home/Work _____

Employer _____

Soc.Sec.# _____ Birthdate _____

Do you have dental insurance coverage for minor/child/self? ☐ Yes ☐ No

GENERAL INFORMATION

What concerns you about your child's/ your teeth? _____

What concerns your child about their teeth? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations: _____

_____

Have any other family members been treated in this office? Please name them: _____

_____

AUTHORIZATIONS

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's/own medical status. I authorize the dental staff to perform the necessary dental services for my minor/child/self.

_____ _____

Signature of Parent/Guardian/Self Date

RELEASE AND ASSIGNMENT

I certify that my minor/child/self is covered by insurance with _____

and assign directly to Tyska Alexander Orthodontics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature of Parent/Guardian/Self Date