CASTAÑEDA ORTHODONTICS

5558 Flamingo Road Cooper City, FL 3332 Tel: 954-434-3043

ORTHODONTIC PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Full Name______________________________Male__Female __Birthdate____/____/______
Patient's Address______________________________✆(_____)____________✉____________________
Patient's Dentist______________________________Phone (_______)________________
Whom may we thank for your referral______________________________
Other family members seen by us?______________________________

RESPONSIBLE PARTY INFORMATION

Responsible Party Name____________________Birthdate____/____/_____Relationship to patient__________
Address if different from patient____________________Phone (_____)__________SSN________________

DENTAL INSURANCE INFORMATION

Name of insured____________________Birthdate____/____/______Relationship to patient________________
Employer of Insured____________________ID Number of Insured______________________
Name of INS company____________________Phone # of Ins Company________________________
Group number___________________

HEALTH HISTORY

MEDICAL HISTORY: Please check if you have/had

ADHD/ADD ☐
Asthma ☐
Reached Puberty ☐
If female, has patient started menstruation ☐ yes ☐ no
When did it first start? ________________________________
Heart Trouble ☐
Heart Murmur ☐
Epilepsy ☐
Artificial Joints ☐
Joint Swelling ☐
Arthritis ☐
Prolonged Bleeding ☐
Diabetes ☐
Tonsils Removed ☐
Please list details______________________________
Hepatitis A,B,C ☐
AIDS/HIV ☐
Please list details______________________________
Are you pregnant? ☐
Please list details______________________________
Seasonal Allergies ☐
Drug Allergies ☐
Latex Allergies ☐ Nickel Allergies ☐
Food/Nut Allergies ☐
Are you presently under a physician's care? Reason

____
Last Yearly Physical______________________________
Physician Name______________________________
Taken/being applied intravenous Bisphosphonates: Fosamax-Aloronate,Zometa-Zoledromic Acid, Actonel-Ridendronate, Boniva-Ibandronate, Didronel-Etidronate, Skelid-Tiludronate to strengthen your bones or for bone disorders or cancer?If yes,please describe______________

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Any medical conditions that you should make us aware of?

Conditions	Medications

DENTAL HISTORY: Please check if you have/had

Date of last cleaning _____________________
Any pending treatment ☐yes ☐no
Any injuries to face, mouth, teeth? ☐
Any clenching/grinding? ☐
Any Habits? Tongue, thumb, finger, lip sucking, smoking, snoring, Others? Please list____________________________
Speech Problems ☐
Frequent Headaches ☐
Any pain, popping, clicking or locking when opening/closing jaw? ☐
Any muscle tenderness or stiffness in the ☐ jaw ☐ neck
Any previous treatment for TMJ or jaw problems? ☐
Mouth Breathing? ☐ Snoring? ☐
Any missing teeth? ☐
Any previous orthodontic evaluation/treatment? ☐
At what age___________ Completed ☐yes ☐no
Reason for treatment____________________________________
Name of Orthodontist____________________________________

NOTES____

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________________________________ ___/___/_______

Zulma Castaneda-Medina, DMD, CAGS Date

________________________________ ___/___/_______

Patient/Parent/Guardian Signature Date

THANK YOU FOR CHOOSING A BOARD CERTIFIED ORTHODONTIST!