Paul W. Reed, DDS, MS
414 Petoskey St., Petoskey, MI 49770 | 150 N. Otsego, Gaylord, MI 49735
(231) 347-4145 | (989) 448-2002

www.paulreedortho.com

Comprehensive Patient Registration Record
All Information Listed is
STRICTLY CONFIDENTIAL

PATIENT INFORMATION – CHILD

Patient's Name: ______________________ Preferred Name: ______________________
Birthdate: ______________________ Age:______________________ Sex: M F
Address: ______________________ City/State/Zip: ______________________
Home Phone:______________________ Email: ______________________
School: ______________________ Grade Level: ______________________
Are there other family members that came to our office? ______________________
Patient's Dentist: ______________________ Who can we thank for referring you? ____________
How do you wish to receive appointment reminders? Email: ______________________
Text: #1 ______________________ #2______________________ #3______________________

RESPONSIBLE PARTY INFORMATION

Father's Information:
Name: ______________________
Date of Birth: ______________________ Social Security #: ______________________
Address (if different than above): ______________________ City/State/Zip: ______________________
Home Phone: ______________________ Cell Phone: ______________________
Work Phone: ______________________ Email: ______________________

Mother's Information:
Name: ______________________
Date of Birth: ______________________ Social Security #: ______________________
Address (if different than above): ______________________ City/State/Zip: ______________________
Home Phone: ______________________ Cell Phone: ______________________
Work Phone: ______________________ Email: ______________________

Please list any additional individuals who may obtain information about patient's treatment:
Name: ______________________ Relationship: ______________________
Name: ______________________ Relationship: ______________________

CHILD MEDICAL HISTORY

PLEASE INDICATE WHETHER OR NOT YOUR CHILD HAS EVER HAD
ANY OF THE FOLLOWING MEDICAL CONDITIONS BY CIRCLING (Y)es or(N)o.

Y	N	Abnormal Bleeding	Y	N	Hemophilia
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	AIDS/Antibody Positive
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Infective Endocarditis	Y	N	Liver Problems
Y	N	Cancer	Y	N	Lupus
Y	N	Convulsions/Epilepsy	Y	N	Migraine Headaches
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Emotional Problems	Y	N	Sickle Cell Disease/Traits
Y	N	Hearing Impairment	Y	N	Tuberculosis
Y	N	Heart Murmur	Y	N	Tonsils Removed-Age:___________
Y	N	Asthma			

ALLERGIES: Y N Medications- If yes, please list:____
Y N Latex Y N Metals Y N Plastic/Acrylic

Is patient currently being seen for any injury or illness? Y N- If yes, please explain: ____________________
Are there any other medical concerns we should be aware of? Y N-If yes, please explain:_____________________
Does patient need to be pre-medicated prior to dental visits? Y N – If yes, do you have prescription filled: Y N

Name of Physician: _____________________________________ Phone:_____________________________________
Please list any medication(s) patient is currently taking, along with reason for the medication(s):
________________________________ ____
________________________________ ____

CHILD DENTAL HISTORY

When did the patient last visit dentist? ____
Why is the patient seeking an orthodontic consultation? ____
Has the patient had prior orthodontic consultation or treatment? Y N- If yes, please explain:____________
____
Is there a history of thumb or finger sucking? Y N- If yes, until what age? ________________________________
Does the patient have any speech problems? Y N- If yes, is patient currently in speech therapy? Y N
Has the patient ever had a severe head, neck or facial injury? Y N- If yes, please explain:_____________________
Does the patient:

- Experience frequent headaches? Y N- If yes, please explain: __________________________________
- Pain or clicking in the jaw joint? Y N- If yes, please explain: __________________________________
- Does the patient clench or grind his/her teeth? Y N- If yes, please explain: _________________________

Have you been informed of any missing or extra permanent teeth? Y N- If yes, please explain: ________________
____

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that is my responsibility to inform the office of Paul W Reed, DDS, MS, PC of any changes in the patient's medical status. I authorize the team of Paul W Reed, DDS, MS, PC to take x-rays and photos that may be needed during diagnosis and treatment, with my informed consent.

Signature of Parent/Guardian: ____ Today's Date:_____________________________