Santa Barbara Office
805-687-7417

Goleta Office
805-964-4786

Child New Patient Registration

Patient Information

Patient's Name:

Gender:

Male Female

Social Security Number

Date of Birth

Home Address

City

State

Zipcode

Primary Phone Number

Phone Type

Home Cell Other

Email Address

School

Grade

List any sports / extracurricular activities

Siblings (names and ages)

Parent/Guardian Information

Parent Marital Status

-- Choose One --

Relationship to Patient

Mother Father

Parent's Name

Social Security Number

Date of Birth

Driver's License Number

Street Address (if different from child's)

City

State

Zipcode

Primary Phone Number

Phone Type

Home Cell Other

Secondary Phone Number

Phone Type

Home Cell Other

Employer

Occupation

Emergency Contact Information

Emergency Contact Name (other than parent)

Phone Number

Relation to Child

Address

City

State

Zipcode

Address

Person(s) OK to release appointment or medically related information to concerning child

Relation to Child

Primary Insurance Information

Primary Insurance Company

Phone Number

Group Number

Policy Number

Member ID Number

Policy Holder's Name

Policy Holder's Birth Date

Employer

Work Phone Number

Co-Pay (if known)

Deductible (if known)

Secondary Insurance Information

Secondary Insurance Company

Phone Number

Group Number

Policy Number

Member ID Number

Policy Holder's Name

Policy Holder's Birth Date

Employer

Work Phone Number

Co-Pay (if known)

Deductible (if known)

Dental History

General Dentist

Date of Last Visit

How did you hear about our practice?

- Ad
- Internet
- Family or Friend
- Physician
- Other

Name of person referring (if applicable)

What are your main orthodontic concerns?

Has your child visited an orthodontist before?

Yes No

When?

For what reason?

Has your child had their tonsils or adenoids removed?

Yes No

Has your child ever experienced jaw pain/discomfort (TMJ/TMD)?

Yes No

Does your child have any missing or extra permanent teeth?

Yes No

Has your child ever had an injury to any of the following?

Teeth Mouth Chin

Does your child have speech problems?

Yes No

If 'yes' please explain

Does your child currently have or ever had any of the following habits?

- Clenching/Grinding Teeth
- Lip Sucking/Biting
- Mouth Breathing
- Nail biting
- Thumb/ Finger Sucking
- Chewing/Eating Problems

Medical History

Is your child currently being treated by a physician?

Yes No

Reason

Physician's Name

Deductible (if known)

Physician's Phone Number

Does your child have any allergies/sensitivities to medications or latex?

Yes No

If 'yes' please list allergies

Is your child currently taking any prescription or over-the-counter medications?

Yes No

If 'yes' please list (with dosages)

Has puberty and/or menstruation begun?

Yes No

Has your child ever taken any of the group of drugs collectively referred to as "fen-phen?"?

Yes No

Has your child had any serious illnesses or operations?

Yes No

If 'yes' please describe

Has your child ever had a blood transfusion?

Yes No

If 'yes' please list approximate dates

Is your child pregnant?

Yes No

Nursing?

Yes No

Taking birth control pills?

Yes No

Check if you have or have ever had any of the following:

Abnormal Bleeding	Anemia	Arthritis or Rheumatism
Artificial Heart Valves	Artificial Joints	Asthma
Back Problems	Blood Disease	Blood Transfusion

Cancer	Chemical Dependency	Chemotherapy
Circulatory Problems	Congenital Heart Defect	Cortisone Treatments
Cough, Persistent	Coughing Blood	Diabetes
Difficulty Breathing	Drug/Alcohol/Abuse	Epilepsy
Emphysema	Fainting	Fever Blisters/Herpes
Glaucoma	Headaches	Heart Attack
Heart Surgery	Heart Murmur	Heart Problems
Hemophilia	Hepatitis	High Blood Pressure
High/Low Blood Sugar	HIV/AIDS	Hospitalized for Any Reason
Jaw Pain	Kidney Disease	Liver Disease
Mitral Valve Prolapse	Pacemaker	Psychiatric Problems
Radiation Treatment	Respiratory Disease	Rheumatic Fever
Scarlet Fever	Shingles	Shortness of Breath
Sickle Cell Disease/Traits	Sinus Problems	Skin Rash
Stroke	Swelling of Feet or Ankles	Thyroid Problems
Tobacco Habit	Tonsillitis	Tuberculosis
Ulcer	Venereal Disease	

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Patient or Responsible Party

Today's date