

**MINOR PATIENT REGISTRATION  
WILSON ORTHODONTICS  
(please print)**

**Date** \_\_\_\_\_

**Patient's First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Last Name** \_\_\_\_\_ **Home Phone #** \_\_\_\_\_

**Patient's Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Sex** \_\_\_\_\_ **Age** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Is his address the same as the patient's?** **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Father's Address** (if different from pt.) \_\_\_\_\_ **Phone** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Father's Employer** \_\_\_\_\_ **Length of Employment** \_\_\_\_\_

**Father's Business Phone** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ (Miss/Mrs/Ms circle one) **Is her address same as the patient's?** **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Mother's Address** (if different from pt.) \_\_\_\_\_ **Phone** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Mother Employer** \_\_\_\_\_ **Length of Employment** \_\_\_\_\_

**Mother's Business Phone** \_\_\_\_\_

**Marital Status of Parents:** (circle one) **Married** **Single** **Separated** **Widowed** **Divorced**

**Name of Person Responsible for Account** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Father's Dental Insurance Company** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Mother's Dental Insurance Company** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Patient's Dentist** \_\_\_\_\_ **Patient's Physician** \_\_\_\_\_

**Were you referred to our office by another patient?** **Name:** \_\_\_\_\_

Please understand that, because most of our patients are school children, it may be necessary to have your child taken out of school for some appointments which require more time to perform.

If someone other than a parent or legal guardian consistently brings the patient to our office for appointments, do we have your permission to share any information, including financial, with them? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

I hereby acknowledge that I have read and understand this form and that all the information I have given above is accurate to the best of my knowledge.

**Signed** \_\_\_\_\_

**PLEASE COMPLETE HEALTH HISTORY ON THE BACK OF THIS FORM**

**ALLERGIES:**

Hay fever? Yes No  
 Dental material? Yes No  
 Latex? Yes No  
 Drugs? Yes No  
 Please list: \_\_\_\_\_

**SERIOUS ILLNESSES:**

Diabetes? Yes No  
 Epilepsy? Yes No  
 Polio? Yes No  
 Tuberculosis? (TB) Yes No  
 Rheumatic Fever? Yes No  
 Heart damage? Yes No  
 Heart murmur? Yes No  
 Radiation treatment? Yes No  
 Hearing difficulty? Yes No  
 Recurrent earaches? Yes No  
 Hemophilia Yes No  
 Thyroid condition? Yes No  
 Recurrent sore throat? Yes No  
 AIDS or HIV? Yes No  
 Hepatitis? Yes No  
 Birth defects? Yes No  
 Other illnesses \_\_\_\_\_

**SERIOUS INJURIES:**

Ever had head injury? Yes No  
 Face injury? Yes No  
 Tooth injury? Yes No  
 Brief description of injury \_\_\_\_\_

**OPERATIONS/HOSPITALIZATIONS:**

Tonsils removed? Yes No  
 Adenoids removed? Yes No  
 Blood transfusions? Yes No  
 Other: \_\_\_\_\_

Joint replacement/Prosthetic Implant?  
 Yes No

Is patient currently taking any medications? Yes No

Is patient currently under a doctor's care?  
 explain \_\_\_\_\_

Has patient had previous orthodontic treatment? Yes No

Does patient have any disease not listed above? Yes No

Does patient require premedication for heart murmur? Yes No

**GROWTH & DEVELOPMENT:**

Abnormal growth pattern? Yes No  
 Recent rapid growth? Yes No

**FEMALE PATIENTS ONLY:**

Any signs of puberty? Yes No  
 Started menstruation Yes No  
 Approximate date \_\_\_\_\_  
 Is patient pregnant? Yes No

**MALE PATIENTS ONLY:**

Any signs of puberty? Yes No

**BREATHING DIFFICULTY? Yes No**

Explain \_\_\_\_\_

**MUSICAL INSTRUMENT \_\_\_\_\_****SPORTS \_\_\_\_\_****ORAL HABITS:**

Thumb/finger sucking habit? Yes No  
 Is this a current habit? Yes No  
 Grinding of teeth? Yes No  
 Chewing difficulties? Yes No

**SPEECH:**

Speech problem? Yes No  
 Is patient in speech therapy? Yes No

**GAGGING PROBLEM? Yes No****DENTAL HEALTH:**

Date of last dental visit \_\_\_\_\_  
 Jaw noises? (clicking/etc.) Yes No  
 Jaw/face pain? Yes No  
 TMJ problems? Yes No  
 Bleeding gums? Yes No  
 Any fillings? Yes No

**LEARNING DISABILITY? Yes No**

Please list medications \_\_\_\_\_

No If yes, please \_\_\_\_\_

If yes, please explain \_\_\_\_\_

I HAVE READ AND UNDERSTAND THIS MEDICAL HISTORY. I WILL NOT HOLD THE OFFICE OF TIMOTHY G. WILSON RESPONSIBLE FOR ANY OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM AND, IF THERE ARE ANY CHANGES TO THIS MEDICAL HISTORY, I WILL NOTIFY THE OFFICE AS SOON AS I AM AWARE OF THEM.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_ DR. \_\_\_\_\_