Date: ____/____/____

CHILD PATIENT REGISTRATION FORM

LAI ORTHODONTICS
Yu-Ching Lai, DDS, MS

PATIENT INFORMATION

First | M.I. | Last | Nickname

Home Address Street | City | State | Zip

Home Telephone | Date of Birth/Age | Grade | School

❍ Boy
❍ Girl

Brothers / Ages | Sisters / Ages

PARENT ❍ Mr. ❍ Ms. ❍ Mrs. ❍ Dr. First | M.I. | Last | SSN

Home Address (If Different) Street | City | State | Zip

Telephone Home | Cell | Office | Email Address

Employer | Business Address

PARENT ❍ Mr. ❍ Ms. ❍ Mrs. ❍ Dr. First | M.I. | Last | SSN

Home Address (If Different) Street | City | State | Zip

Telephone Home | Cell | Office | Email Address

Employer | Business Address

In case of emergency, contact: | Telephone

Who may we thank for this referral?

BILLING

Who will pay for the account?
❍ Father ❍ Mother ❍ Other

Billing Name (If Different)

Billing Address Street | City | State | Zip

Do you have orthodontic insurance coverage? ❍ Yes ❍ No
If DUAL COVERAGE, make sure to complete both primary and secondary carrier sections.

INSURANCE

Primary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | Date of Birth

Secondary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | *Date of Birth*

PATIENT'S HEALTHCARE PROVIDERS

MEDICAL HISTORY

Physician's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Yes	No	
❍	❍	Has patient undergone a complete physical exam in the past year?
❍	❍	Is patient presently under a physician's care?
❍	❍	Has patient had major surgery?
❍	❍	Has patient ever been hospitalized?
❍	❍	Is patient taking any pills, drugs or medications? (List below under Additional comments)
❍	❍	Is patient allergic to any medication? (List below)
❍	❍	Has patient had any unusual reaction to a medication?
❍	❍	Has patient taken any diet medication (i.e., Fen-Fen)?
❍	❍	Has patient had tonsils and/or adenoids removed?
❍	❍	Does patient have fainting or dizzy spells?
❍	❍	Does patient have high or low blood pressure?
❍	❍	Has puberty begun?
❍	❍	For girls: Has menstruation begun?

List any musical instruments played: _____

Additional explanations or comments:

Check whether the patient has/had any of the following conditions:

❍ Heart Problems	❍ Diabetes
❍ Hepatitis	❍ Endocrine Problems
❍ Kidney Problems	❍ Bone Disorders
❍ Rheumatic Fever	❍ Arthritis
❍ Lung Problems	❍ Prolonged Bleeding
❍ Nervous Problems	❍ Anemia
❍ Liver Problems	❍ Asthma
❍ Psychiatric Care	❍ Tuberculosis
❍ Allergies	❍ Epilepsy
❍ Malignancies	❍ HIV+/AIDS

Is patient allergic or has reacted adversely to:

Yes	No	
❍	❍	Local anesthetics
❍	❍	Penicillin/other antibiotics
❍	❍	Sulfa drugs
❍	❍	Barbiturates, sedatives or sleeping pills
❍	❍	Aspirin
❍	❍	Codeine or other narcotics
❍	❍	Latex
❍		Other: _____

DENTAL HISTORY

Dentist's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Date of last dental exam: _____

What bothers the patient most about his/her teeth?

What do you and your child expect from orthodontic treatment?

Yes	No	
❍	❍	Has patient had previous orthodontic consultation or treatment?
❍	❍	Has patient been informed of any extra or missing teeth?
❍	❍	Have any permanent teeth been removed by extraction?
❍	❍	Does patient suck his/her thumb or finger?
❍	❍	Does patient breathe predominantly through the mouth?
❍	❍	Does patient have any speech problems?
❍	❍	Does patient have pain or clicking in the jaw?
❍	❍	Has patient ever had pains in the face or head?
❍	❍	Have any teeth been injured or chipped due to an accident?
❍	❍	Has patient ever had a severe face or jaw injury?
❍	❍	Do patient's gums bleed on brushing or flossing?
❍	❍	Is patient concerned about appearance of his/her teeth?
❍	❍	Does patient want his/her teeth straightened?

ARE THERE ANY OTHER DENTAL / ORTHODONTIC PROBLEMS WE SHOULD BE AWARE OF?

Parent's Signature: _____ **Date:** _____

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(MINOR)

I have received a copy of the Notice of Privacy Practices of ***Lai Orthodontics.*** I hereby authorize, as indicated by my signature below, ***Lai Orthodontics*** to use and to disclose my child's protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print (Parent) Name Address

_____ _____

Parent Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date: Added / Removed:_____

2. _____ Date: Added / Removed: _____

3. _____ Date: Added / Removed: _____

4._____ Date: Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____