

Michael F. Grosso, DMD
CHILD REGISTRATION

No. _____

PATIENT'S NAME _____ NICKNAME _____

BIRTHDATE _____ AGE _____ SEX _____ MALE _____ FEMALE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

PHYSICAL ADDRESS (IF (DIFFERENT)) _____

HOME PHONE _____ WORK PHONE _____ CELL OR PAGER# _____

E-MAIL ADDRESS _____ HOW DID YOU HEAR ABOUT US? _____

SCHOOL PATIENT ATTENDS _____

DENTIST _____ PHYSICIAN _____

FATHER'S FULL NAME _____ EMPLOYED BY _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

MOTHER'S FULL NAME _____ EMPLOYED BY _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

BROTHER'S NAME _____ SISTER'S NAME _____

FAMILY MEMBER THAT ARE PATIENTS IN OUR ORTHODONTIC PRACTICE _____

SPORTS & HOBBIES _____ MUSICAL INSTRUMENTS PLAYED _____

HAS PATIENT EVER HAD ANY PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT? _____ YES _____ NO

REMARKS _____

CHIEF DENTAL COMPLAINT _____

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1.	Has there been any change in your general health within the past year.....	YES	NO
2.	My last physical examination was on _____		
3.	Are you now under the care of a physician.....	YES	NO
	a. If so, what is the condition being treated _____		
	Have you had any serious illness or operation.....	YES	NO
	a. If so, what was the illness or operation _____		
	Have you been hospitalized or had a serious illness within the past 5 years	YES	NO
	a. If so, what was the problem _____		
	Do you have or have you had any of the following diseases or problems		
	a. Rheumatic fever or rheumatic heart disease.....	YES	NO
	b. Congenital heart lesions	YES	NO
	c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis stroke)	YES	NO
	1) Do you have pain in chest upon exertion	YES	NO
	2) Are you ever short of breath after mild exertion.....	YES	NO
	3) Do your ankles swell.....	YES	NO
	4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep	YES	NO
	d. Allergy	YES	NO
	e. Sinus Trouble	YES	NO
	f. Asthma or hay fever.....	YES	NO
	g. Hives or a skin rash	YES	NO
	h. Fainting spells or seizures.....	YES	NO
	i. Diabetes.....	YES	NO
	1) Do you have to urinate (pass water) more than six times a day	YES	NO
	2) Are thirsty much of the time.....	YES	NO
	3) Does your mouth frequently become dry	YES	NO
	j. Hepatitis, jaundice or liver disease	YES	NO
	k. Arthritis.....	YES	NO
	l. Inflammatory rheumatism (painful swollen joints).....	YES	NO
	m. Stomach Ulcers	YES	NO
	n. Kidney Trouble	YES	NO
	o. Tuberculosis	YES	NO
	p. Do you have a persistent cough or cough of blood.....	YES	NO
	q. Low blood pressure.....	YES	NO
	r. Venereal disease	YES	NO
	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma	YES	NO
	a. Do you bruise easily.....	YES	NO
	b. Have you ever required a blood transfusion.....	YES	NO
8.	Do you have any blood disorder such as anemia	YES	NO
9.	Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips	YES	NO
10.	Are you taking any drug or medicine	YES	NO
11.	Are you taking any of the following:		
	a. Antibiotics or sulfa drugs	YES	NO
	b. Anticoagulants (blood thinners)	YES	NO
	c. Medicine for high blood pressure.....	YES	NO
	d. Cortisone (steroids).....	YES	NO
	e. Tranquilizers	YES	NO
	f. Antihistamines.....	YES	NO
	g. Aspirin	YES	NO
	h. Insulin, tolbutamide (Orinase) or similar drug	YES	NO
	i. Digitalis or drugs for heart trouble	YES	NO
	j. Nitroglycerine.....	YES	NO
	k. Other _____		
12.	Are you allergic or have you reacted adversely to:		
	a. Local anesthetics.....	YES	NO
	b. Penicillin or other antibiotics.....	YES	NO
	c. Sulfad drugs	YES	NO
	d. Barbiturates, sedatives, or sleeping pills.....	YES	NO
	e. Aspirin	YES	NO
	f. Iodine	YES	NO
	g. Codeine or other narcotics.....	YES	NO
	h. Other _____		
13.	Have you had any serious trouble associated with any previous dental treatment.....	YES	NO
	If so, explain _____		
	Do you have any disease, condition, or problem not listed above that you think I should know about.....	YES	NO
	If so, explain _____		
15.	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation.....	YES	NO
16.	Are you wearing contact lenses	YES	NO
17.	Are you pregnant.....	YES	NO
18.	Do you have any problems associated with your menstrual period	YES	NO
19.	HIV Positive.....	YES	NO

Signature