700 Western Ave, Suite 100 Minot, ND 58701
701-838-1700 www.burckhardortho.com

Child/Adolescent Patient Registration

Today's date: _____/_____/_____
Patient name: ____ Nickname: _____________________ Sex: M or F
Date of birth: _____/_____/_____ Age: ____________ Child by: birth or adoption
Home phone: (______) _______________
Patient's address: ____City: _________________State: ______Zip: _______
Grade: _________ School: ____ City: __________________________
Patient's dentist: ____ Date of last cleaning and exam: _____/_____/_____
Patient's physician: ____ Clinic: _______________________________
Name(s) and ages of other children: ____
Name(s) of other family members seen in our office: ____
Child/adolescent's hobbies and activities: ____
Who is accompanying child/adolescent today: __________________________________Relationship: _______________
How did you find out about our office: ____

Responsible party/parent information

Father's Name: ____ Date of birth: _____/_____/_____
o Married o Widowed o Separated o Divorced o Single Spouse's name:__________________________________
Home phone: (_______) ____________________ Work phone: (_______) _____________________
Cell phone: (_______) ______________________ Email address: ____
Address: ____City: _________________State: ______Zip: _______
Employer:____ Occupation: ____________________________________

Mother's Name: ____ Date of birth: _____/_____/_____
o Married o Widowed o Separated o Divorced o Single Spouse's name:__________________________________
Home phone: (_______) ____________________ Work phone: (_______) _____________________
Cell phone: (_______) ______________________ Email address: ____
Address: ____City: _________________State: ______Zip: _______
Employer:____ Occupation: ____________________________________

Who is the financially responsible party for the child/adolescent: Father or Mother or Other:__________________

Dental insurance information

*****If you do have dental insurance, please bring the card to your appointment.**

Orthodontic coverage: Yes No Lifetime maximum of coverage $ (if known):_____________________________
Primary insurance co. name: ______________________________________ Subscriber name:______________________
ID # ____________________________Group # ____________________Effective date of coverage: _____/_____/_____
Address: ____City: _________________State: ______Zip: _______
Phone number: (_______) _____________________________

Secondary insurance co. name: ____________________________________ Subscriber name:______________________
ID # ____________________________Group # ____________________Effective date of coverage: _____/_____/_____
Address: ____City: _________________State: ______Zip: _______
Phone number: (_______) _____________________________

Burckhard Orthodontics

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Patient's medical history

Y N Is the patient in good health? If no, explain: ______________________________
Y N Does the patient have any history of major illness? ______________________________
Y N Is the patient allergic to any medications/foods/other? ______________________________
Y N Is the patient currently taking any medications? ______________________________
Y N Is the patient currently under the care of a physician? ______________________________
If yes, for what reason: ______________________________
Y N Does the patient require pre-medication such as antibiotics for dental visits due to a medical condition?
If yes, what is the indication for pre-medication: ______________________________

Y N Abnormal bleeding	**Y N Cleft lip/palate**	**Y N Hospital stays/surgeries**
Y N AIDS / HIV positive	**Y N Diabetes**	**Y N Kidney problems**
Y N ADHD	**Y N Disabilities**	**Y N Liver problems**
Y N Anemia	**Y N Epilepsy/seizures**	**Y N Low blood pressure**
Y N Arthritis	**Y N Hearing problems**	**Y N Pregnant (females only)**
Y N Asthma	**Y N Heart disease**	**Y N Rheumatic fever**
Y N Autism	**Y N Heart murmur**	**Y N Speech problems**
Y N Breathing problems	**Y N Hemophilia Type________**	**Y N Sickle cell anemia**
Y N Cancer	**Y N Hepatitis Type__________**	**Y N Tobacco use**
Y N Cerebral palsy	**Y N High blood pressure**	**Y N Tuberculosis (TB)**

If yes to any of the above, please explain: ______________________________
____
Any other medical conditions: ______________________________
____

Patient's dental history

Why did you come to Burckhard Orthodontics: ______________________________
____
Y N Does the patient want orthodontic care? Does the patient prefer: Braces Invisalign Open to either option
Y N Has the patient had any injuries to the face, mouth, teeth, or chin: ______________________________
Y N Has the patient had a recent panoramic x-ray taken? If so, where: ______________________________
Y N Has an orthodontist been consulted previously? ______________________________
If yes, who did you see and date of consultation: ______________________________
Y N Has the patient been informed of any missing permanent teeth?
Y N Has the patient been informed of any extra permanent teeth?
Y N Thumb sucking habit
Y N Finger(s) sucking habit (any finger(s) other than the thumb)
Y N Lip sucking or biting
Y N Nail biting
Y N Clenching or grinding teeth
Y N Any clicking, popping, or jaw pain? If yes, please explain: ______________________________
Y N Is the patient actively growing? Current height _________ Current weight __________
Y N Any family member(s) who have had braces and where? ______________________________
Y N Has the patient previous orthodontic treatment? If yes, where and when? ______________________________

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Please rate the following with 5 being the most important and 1 being the least important.

5	**4**	**3**	**2**	**1**	**Quality of treatment**
5	**4**	**3**	**2**	**1**	**Starting treatment within the next month**
5	**4**	**3**	**2**	**1**	**Length of treatment**
5	**4**	**3**	**2**	**1**	**Comfort of treatment**
5	**4**	**3**	**2**	**1**	**Latest technology for treatment**
5	**4**	**3**	**2**	**1**	**Clear or invisible treatment options**
5	**4**	**3**	**2**	**1**	**Low monthly payments**
5	**4**	**3**	**2**	**1**	**Low down payment**

I have truthfully answered all of the questions and agree to inform Burckhard Orthodontics of any changes in the patient's contact information or medical/dental history. In addition, I authorize Burckhard Orthodontics to perform a complete orthodontic evaluation:

Signature: ____ Date: _____/_____/_____
Relationship to patient: ____