



LISA P. HOWARD, D.D.S., M.S.
CHRISTOPHER A. MURPHY, D.M.D., M.D.S.

306 U.S. Route 1
Building D, Suite 1
Scarborough, ME 04074
207-885-1005

www.southernmainebraces.com
www.facebook.com/southernmaineorthodontics

Child Registration Form

Date: _____

Patient's Full Name: _____

Does the patient have a nickname? _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email Address: _____

Birth Date: _____ School: _____ Grade: _____

Whom should we thank for referring you to our office? _____

Name of patient's general Dentist: _____ Last Visit: _____

Has anyone in your family been treated in our office? _____

Sibling(s) & age(s): _____

Parent/Guardian	Parent/Guardian
Name: _____	Name: _____
Address: _____	Address: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Home Phone: _____	Home Phone: _____
Business Phone: _____	Business Phone: _____
Mobile Phone: _____	Mobile Phone: _____
Mobile Carrier: _____	Mobile Carrier: _____

Person responsible for the account: _____

Person responsible for making appointments: _____

Please circle how you would you like to receive appointment reminders: Email Text Message Both

Please help us to understand your child's dental condition and experiences by answering the following:

Has your child ever had:

Y N Abscessed or extracted teeth?

Y N Injured or chipped teeth?

Y N Any severe head injuries?

Y N Sore or bleeding gums?

Y N Limited opening of jaw?

Y N Numbness or tingling of the face?

Y N Previous orthodontic treatment? _____

Y N Bleeding that was hard to stop?

Y N Been hospitalized? If so, for what? _____

Y N Is your child allergic to any drug or other substances? If so, what? _____

Please list all medications your child is currently taking: _____

Females: Has your child started menstruating? Yes No At what age? _____

Males: Has your child's voice changed? Yes No At what age? _____

Describe your child's current overall health: (circle one) Excellent Good Fair Poor

Has/Does your child:

Y N Suck fingers or thumb? Until what age: _____

Y N Breath predominately through their mouth?

Y N Clench or grind their teeth?

Y N Have missing permanent teeth?

Y N Have extra permanent teeth?

Y N Do any family members have a similar condition?

Y N Is your child **allergic** to Latex?

Please Circle All Conditions That Apply

Heart murmur

Heart surgery

Rheumatic/Scarlet fever

Heart pacemaker

Artificial heart valve

Artificial joints

High/Low blood pressure

Shortness of breath

Chest pains

Tactile defensive

Hives/Rash

ADD/ADHD

Frequent headaches

Depression

Thyroid disorder

Sinus trouble

Hepatitis

Asthma

Tuberculosis

Bronchitis

Hay fever/Allergies

Epilepsy

Fainting

Aids/HIV

Emotional problems/issues

Diabetes

Nervous/Anxious

Immune system disorders

STD

Autism

Has your child:

Expressed objections to wearing braces or headgear? **Y N**

Expressed anxiety about treatment? **Y N**

Been teased about the appearance of their teeth? **Y N**

Been interested in having their teeth straightened? **Y N**

Had an orthodontic evaluation before? **Y N** If yes, how long ago? _____ Was treatment recommended? **Y N**

Has any member of your family experienced orthodontic treatment? **Y N** If yes, who? _____

Are you aware that some of your child's orthodontic appointments will infringe on school time? **Y N**

Who first noticed the need for orthodontic treatment? _____

What is your main reason for seeking an orthodontic evaluation today? _____

Is there any condition or other information that you think would be helpful for us to know about before we meet your child?

Parent or Guardian Signature

Today's Date

Welcome Form

We would like to get to know you better.
Please give us some information
about yourself and the things that you like to do.



LISA P. HOWARD, D.D.S., M.S.

CHRISTOPHER A. MURPHY, D.M.D., M.D.S.

Your Full Name: _____

Do you have a Nickname? _____

What kind of music do you like and who are your favorite performers or groups? _____

What kind of books or movies do you like? _____

Are you involved in sports, dance or other extracurricular activities? _____

Do you have any hobbies? _____

Do you play any musical instruments? _____

Is there a subject you like most in school? _____

What would you like to do when you finish school? _____

Do any of your friends come to our office? If so, who? _____

Are you on facebook? Y N Please join us @ [www.facebook.com/ southernmaineorthodontics](http://www.facebook.com/southernmaineorthodontics)