Welcome to Periago Orthodontics!

Dr. Danielle Limeberry Periago DMD, MS

Patient Registration, Adult Patients

Date _____

First Name _____ Last Name _____

Nickname _____ Birthday _____ Age _____ Gender M/F

Home Address _____ City/State/ZIP _____

Home Phone _(___)_____ Cell Phone _(___)_____ Other _(___)_____

Who may we thank for referring you to our office? _____

Responsible Party Information

Full Name _____ Title ___ Mrs. ___ Ms. ___ Dr. ___ Other

Occupation _____ Employer _____

Home Address *(if different)* _____ City/State/ZIP _____

Home Phone _(___)_____ Cell Phone _(___)_____ Other _(___)_____

E-mail Address _____

General Information

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Describe any previous treatment or consultations _____

Dentist Information

Patient's Dentist _____ Location _____

Last Routine Cleaning _____ Next Appointment _____

Other Dentists/Specialists Being Seen _____ Location _____

Reason _____

Have any other family members been treated in our office? If so, who? _____

Dental & Medical Health Questionnaire

Date _____

Patient Name _____ Birthday _____

Currently under the care of a physician? _____

Ever been hospitalized or treated for a serious illness? _____

Any drug allergies? If yes, please list medications. _____

Currently taking any medications? If yes, please list. _____

Does your child require pre-medication before dental treatment? _____

Please check any of the following that apply:

Y/N		Y/N	
o o	Abnormal bleeding	o o	Finger/Thumb Sucking
o o	Plastic/Metal Allergy	o o	Tooth/Jaw Trauma
o o	Latex Allergy	o o	Lip/Tongue Biting
o o	Epilepsy/Convulsions	o o	Cavitites Now
o o	Thyroid Problems	o o	Smoke/Chew Tobacco
o o	Kidney/Liver Problems	o o	Missing Permanent Teeth
o o	Heart Murmur	o o	Clencing or Grinding
o o	Tonsil/Adenoid Problems	o o	Mouth Breathing
o o	Cancer or Tumor	o o	Tongue Thrust
o o	Fainting/Dizziness	o o	Extra Teeth
o o	Tuberculosis	o o	Headaches
o o	Hepatitis (Type ___)	o o	High Blood Pressure
o o	Asthma	o o	HIV Positive
o o	Diabetes (Type ___)	o o	Pregnant Now
o o	Hemophilia	o o	Has your child ever taken oral or intravenous biophosphates
o o	Disabilities		

Please list any Disease, Medical or Dental Condition that is not mentioned above:

_____

Dental Insurance Information

Policy Holder's Full Name _____ Date of Birth _____

Relationship to Patient _____ Social Security Number _____

Employer _____ Address _____

Insurance Company _____ Group# _____ ID# _____ Does your policy have Orthodontic Benefits? ___ Yes ___ No ___ Unsure

I verbally reviewed all medical and dental information above with the patient/parent/guardian names herein.

Doctor Signature _____ Date _____

Medical History Updates or Changes

Change _____ Date _____

Respnsible Party Signature _____

Witness _____

Release and Waiver

I authorize release and any information regarding my child's orthodontic treatment to my dental insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____