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Orthodontists

PATIENT REGISTRATION FORM – PLEASE COMPLETE FULLY –

Patient's Name _____ Male ____ Female ____
Mother's Name _____
Father's Name _____
Parents' Marital Status: married / single / separated / divorced / widowed

PATIENT HEALTH INFORMATION

Has the patient ever had any of the following? (**Please circle**)

Rheumatic Fever	yes no	Diabetes	yes no
Heart Disease	yes no	Hay Fever	yes no
Asthma	yes no	Kidney Disease	yes no
Liver Disease	yes no	Bleeding Disorders	yes no
Hepatitis	yes no	Tonsils and/or adenoids removed	yes no
Positive H.I.V.	yes no	Head / Facial injuries	yes no

Does the patient have any drug allergies? (If yes, indicate them bellow) _____ yes no

Does the patient have any other allergies? (If yes, indicate them below) _____ yes no

Is antibiotic premedication required prior to dental treatment? _____ Yes no
Is there any discomfort when chewing, opening, or closing mouth? _____ Yes no
Is the patient aware of any TMJ problems (click, pain, locking, etc.)? _____ Yes no
Does the patient visit their family dentist on a regular basis? _____ Yes no
Has another family member had braces or other orthodontic treatment? _____ Yes no
Name of family member (If treated in out office) _____
Whom may we thank for referring you to our office? _____
Reason for visit our office? _____

Signature of Parent or Guardian Date