Print Form

KAMLESH G PATEL, D.M.D., P.A.
CHILD REGISTRATION AND MEDICAL DENTAL HISTORY FORM (UNDER 18 YEARS OF AGE)

Patient's Last Name: _____ First Name: _____ Middle Name/Initial: _____

Birth Date: _____ Age: _____ Sex: ❑Male ❑Female Nickname: _____

Patient's Home Phone No.: _____ S.S.N. /S.I.N.: _____E-Mail: _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Attends School at: _____ Grade: _____

Sports/Hobbies: _____

Name of other family members treated at this office: _____

Parent's Marital Status: ❑Single ❑Married ❑Partnered ❑Widowed ❑Divorced ❑Separated

Father's Name: _____ Legal Custody of the child? ❑Yes ❑No

Father's Address: (if different than patients): _____

Father's Occupation: _____ Daytime Phone No.: _____ Cellular Phone No.: _____

Mother's Name: _____ Legal Custody of the child? ❑Yes ❑No

Mother's Address: (if different than patients): _____

Mother's Occupation: _____ Daytime Phone No.: _____ Cellular Phone No.: _____

Birth Father's Height: _____ ft. _____ in. Birth Mother's Height: _____ ft. _____ in.

Patient's Birth Weight: _____ lbs. _____ oz. Patient's Present Weight: _____ lbs. Height: _____ ft. _____ in.

Name of Relative or Friend not living with you that we can contact in case of an emergency: _____

Relationship of this individual to the patient: _____ Emergency Contact Phone No.: _____

Who Is Financially Responsible For This Account? **Financially Responsible Party must be present prior to beginning any treatment.**

Last Name: _____ First Name: _____ Middle Name: _____

Address (if different than patients): _____

Home Phone No.: _____ Cell Phone No.: _____ Office Phone No.: _____

Who suggested that your child might need orthodontic treatment? _____

How did you hear about our office? _____

Why did you select our office? _____

Name of the patient's ❑Present ❑Previous Dentist: _____ Phone No.: _____

Date of Last Dental Visit: _____ Reason for the Last Visit: _____

Dentist's Address: _____

Name of Patient's Physician: _____ Phone No.: _____

Address: _____

INSURANCE INFORMATION:

Do you have Insurance Coverage for Dental Treatment? ❑Yes ❑No **Insurance Coverage For Orthodontic Treatment? ❑Yes ❑No**

Primary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birth Date: _____ Employer Name: _____

Dental Insurance Company: _____ Group No.: _____

Secondary Policy Holder's Name: _____ S.S.N./S.I.N.: _____

Birthdate: _____ Employer Name: _____

Dental Insurance Company: _____ Group No.: _____

Medical Insurance Company Name: _____ Phone No.: _____

MEDICAL AND DENTAL HISTORY SECTION

A thorough, complete and accurately completed history is vital to a proper orthodontic evaluation and treatment. Treatment recommendations and/or treatment plan(s) may be based upon the following responses. The answers provided below are for office records only and will be considered confidential.

PLEASE MARK THE RESPONSES AS YES, NO, DK/U (DON'T KNOW and or UNDERSTAND).

PATIENT PROFILE:

❑Yes ❑No ❑dk/u Does the patient follow directions well?

❑Yes ❑No ❑dk/u Does the patient brush his or her teeth conscientiously?

❑Yes ❑No ❑dk/u Does the patient eat a well balanced diet?

❑Yes ❑No ❑dk/u Is the patient sensitive or self-conscious about teeth?

❑Yes ❑No ❑dk/u Does the patient have any learning disabilities or need extra help with instructions?

MEDICAL HISTORY:

Has the patient now or in the past, have ever had:

❑Yes ❑No ❑dk/u Birth defects or hereditary problems?

❑Yes ❑No ❑dk/u Eye, Ear, Nose or Throat Conditions?

❑Yes ❑No ❑dk/u Tonsil or adenoid conditions? Removed?

❑Yes ❑No ❑dk/u Vision, Hearing, Taste or Speech problems?

❑Yes ❑No ❑dk/u Frequent headaches, colds or sore throats?

❑Yes ❑No ❑dk/u Fainting spells, seizures, epilepsy or neurological problems?

❑Yes ❑No ❑dk/u Mental health disturbance or depression?

❑Yes ❑No ❑dk/u Asthma, sinus trouble, hayfever or hives?

❑Yes ❑No ❑dk/u Endocrine, Thyroid, Diabetes, Immune system problems?

❑Yes ❑No ❑dk/u AIDS or HIV positive?

❑Yes ❑No ❑dk/u Hepatitis, Jaundice or Liver problems?

❑Yes ❑No ❑dk/u Polio, mononucleosis, tuberculosis, pneumonia?

❑Yes ❑No ❑dk/u Cancer, tumor, radiation treatment or chemotherapy?

❑Yes ❑No ❑dk/u Stomach ulcer or hyperacidity?

❑Yes ❑No ❑dk/u Loss of weight or poor appetite recently?

❑Yes ❑No ❑dk/u History of eating disorders (anorexia, bulimia)?

❑Yes ❑No ❑dk/u Rheumatoid, arthritic conditions or osteoporosis?

❑Yes ❑No ❑dk/u Any bone fractures or any major accidents?

❑Yes ❑No ❑dk/u Cardiovascular problems (heart trouble, heart attack, angina, stroke, inborn heart defects, heart murmur, mitral valve prolapse, rheumatic heart disease, coronary insufficiency or any heart or related cardiovascular diseases or disorders or conditions)?

❑Yes ❑No ❑dk/u Does the patient require any PRE-MEDICATIONS prior to any Dental Procedures due to any Medical Conditions?

❑Yes ❑No ❑dk/u Chest pain, shortness of breath or swelling ankles?

❑Yes ❑No ❑dk/u High blood pressure or low blood pressure?

❑Yes ❑No ❑dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorders?

❑Yes ❑No ❑dk/u Kidney problems?

❑Yes ❑No ❑dk/u Get tired easily?

❑Yes ❑No ❑dk/u Skin or dermatologic disorders?

IS THE PATIENT ALLERGIC TO AND/OR HAS EVER HAD ANY ADVERSE REACTIONS TO THE FOLLOWING?

❑Yes ❑No ❑dk/u Local anesthetics (Novocaine or Lidocaine)

❑Yes ❑No ❑dk/u Aspirin

❑Yes ❑No ❑dk/u Ibuprofen (Motrin, Advil)

❑Yes ❑No ❑dk/u Penicillin or other antibiotics

❑Yes ❑No ❑dk/u Sulfa drugs

❑Yes ❑No ❑dk/u Codeine or other narcotics

❑Yes ❑No ❑dk/u Metals (jewelry, clothing snaps etc.,)

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❑Yes ❑No ❑dk/u Latex or plastics (gloves, balloons)

❑Yes ❑No ❑dk/u Vinyl

❑Yes ❑No ❑dk/u Acrylic

❑Yes ❑No ❑dk/u Animals: (specify)_____

❑Yes ❑No ❑dk/u Foods: (specify) _____

❑Yes ❑No ❑dk/u Any other substances? (specify) _____

LIST ALL MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING:

Is the patient presently taking any medication(s), nutrient supplements, herbal medications or any non-prescription (over-the-counter) medicines?
Please list each medication.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

❑Yes ❑No Is that patient now taking or have ever taken in the past, medications knows as "Bisphosphonates"?

❑Yes ❑No Does the patient currently have or have ever had a substance abuse problem?

❑Yes ❑No Does the patient smoke or chew tobacco?

PRESENT OR PAST MEDICAL CARE:

Is the patient **currently under treatment by any other health care professional**?

For: _____

Date of the most recent physical examination? _____

Does the patient have any medical conditions or any problems that may interfere with orthodontic treatment or that we should know about? _____

_____

Does the patient have any physical problems or symptoms that we should now about? Explain: _____

SURGICAL AND HOSPITALIZATION HISTORY:

Has the patient ever had any **operation(s) or surgery(s) (year/procedure)**?
Describe: _____

_____

Has the patient ever been **hospitalized (Please provide year/reason)**?

Describe: _____

_____

FOR GIRLS ONLY:

❑Yes ❑No ❑dk/u Has the patient started her monthly periods?
If yes, approximately when? Month and Year _____

❑Yes ❑No ❑dk/u Is the patient pregnant?

FOR BOYS ONLY:

❑Yes ❑No ❑dk/u Have you noticed any increase in the patient's height recently? If yes, approximately when? _____

❑Yes ❑No ❑dk/u Have you noticed any changes in the voice recently? If yes, approximately when? _____

FAMILY HISTORY:

Does the patient's parents or siblings have or have ever had any of the following health problems? If so, please explain:
Jaw Size Imbalance: _____

Unusual dental problems: _____

Severe allergies: _____

Diabetes, Arthritis, Bleeding Disorders: _____

Any medical conditions that we should know about? _____

DENTAL HISTORY:

Has the patient now or in the past, have ever had:

❑Yes ❑No ❑dk/u Started teething very early or late?

❑Yes ❑No ❑dk/u Primary ("Baby'), Permanent or "extra" (supernumerary) teeth removed that were not loose?

❑Yes ❑No ❑dk/u Supernumerary (extra) or congenitally missing teeth?

❑Yes ❑No ❑dk/u Chipped or otherwise injured primary (baby) or permanent teeth?

❑Yes ❑No ❑dk/u Teeth sensitive to hot or cold, teeth throb or ache?

❑Yes ❑No ❑dk/u Jaw fractures, cysts or mouth infections?

❑Yes ❑No ❑dk/u "Dead teeth" or root canals treated?

❑Yes ❑No ❑dk/u Bleeding gums, bad taste or mouth odor?

❑Yes ❑No ❑dk/u Periodontal "gum problems"?

❑Yes ❑No ❑dk/u Food impaction between teeth?

❑Yes ❑No ❑dk/u "Gum Boils", frequent canker sores or cold sores?

❑Yes ❑No ❑dk/u Thumb, finger, or sucking habit? Until what age? _____

❑Yes ❑No ❑dk/u Abnormal swallowing habit (tongue thrusting)?

❑Yes ❑No ❑dk/u History of speech problems? Any speech therapy?

❑Yes ❑No ❑dk/u Mouth breathing habit, snoring or difficulty in breathing?

❑Yes ❑No ❑dk/u Tooth grinding or jaw clenching?

❑Yes ❑No ❑dk/u Any pain or soreness of the muscles of the face or around the ears?

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❑Yes ❑No ❑dk/u Difficulty in chewing or jaw opening?

❑Yes ❑No ❑dk/u Have you ever been treated for "TMD" or "TMJ" problems?

❑Yes ❑No ❑dk/u Aware of loose, broken or missing restorations (fillings)?

❑Yes ❑No ❑dk/u Any teeth irritating cheek, lip, tongue or palate?

❑Yes ❑No ❑dk/u Concerned about spaced, crooked or protruding teeth?

❑Yes ❑No ❑dk/u Any relative or siblings with similar tooth or jaw relationships?

❑Yes ❑No ❑dk/u Any wisdom ("third molars") tooth problems?

❑Yes ❑No ❑dk/u Had any serious trouble with any previous dental treatment?

Has the patient been under another dentist's or dental specialist's care?

Dentist: List each one: _____

Specialist: List each one: _____

Specialist: List each one: _____

Specialist: List each one: _____

How often does the patient brush per day? ❑ Once ❑ Twice ❑ After each meal

How often does the patient Floss per day? ❑ Once ❑ Twice ❑ Never

How often does the patient see his/her family dentist for routine dental care?

❑ Regularly ❑ Sometimes ❑ Only when there is a problem ❑ Rarely ❑ Never

❑Yes ❑No ❑dk/u Does the patient take or has ever taken any form of Fluoride?

If yes, when and for how long taken? _____

If braces or orthodontic appliances are indicated, would the patient have any objections in wearing braces or orthodontic appliances? ❑Yes ❑No

What is your primary concern? Why are you here? _____

_____

_____

_____

_____

_____

Have you ever had a prior orthodontic examination or evaluation or any orthodontic or "TMJ" treatment by any other orthodontist or dentist(s)? Please list each one including the dates of previous examinations and list any treatment(s) provided in the past or presently.

_____

_____

_____

_____

_____

ACKNOWLEDGEMENT:

I hereby acknowledge that I have read and fully understand the above questions. I have answered the questions truthfully to the best of my knowledge and ability regarding the above referenced patient. I will not hold my orthodontist or any member of his or her staff or this office for any errors or omissions or if I have intentionally not answered any of the above questions that I have made in completion of this form. I can read and comprehend the English language. If there are any changes later on to this record and or medical and or dental information contained herein regarding the above referenced patient, I will so inform this practice in writing by completing and updating a history record(s) form.

I authorize the orthodontist(s) and his or her staff and this office to perform any necessary dental and or orthodontic services that the above patient may need during diagnosis and treatment as deemed appropriate. I understand that the orthodontic treatment fee covers only the treatment provided by this office and that treatment provided by other dental or medical professionals is not included in the fee of the orthodontic treatment.

CONSENT TO UNDERGO ORTHODONTIC RECORDS:

I understand that in order to provide a consultation, this office may take or require preliminary records that may include Photographs and or Radiographs and other Diagnostic Records and I hereby consent to the making of Preliminary Diagnostic Records to the above Doctor(s), his/her staff and this office for the above referenced individual.

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION:

I hereby authorize this office, the treating Doctors and Staff, to provide other health care providers with information regarding the above individual's orthodontic findings and care as deemed appropriate. I understand that once released, the above doctors(s) and staff has (have) no responsibility for any further release by the individual(s) receiving this information. The release of this information may be by but not limited to: e-mail, mail, phone call(s) or in person communication(s) – orally or in writing.

CONSENT FOR THE USE OF RECORDS:

I hereby give my permission for the use of the orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals.

I understand that this office reserves the right to verify the credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signed: _____ Date: _____
(Parent or Legal Custodian)

Signed: _____ Date: _____
(Dental Staff Member or Orthodontist)

BELOW AREA FOR OFFICE USE ONLY

DIRECTIONS TO MAPLE LAWN ORTHODONTICS

7625 Maple Lawn Boulevard | Suite 250 | Fulton | Maryland 20759
Phone 301.776.9500
E-Mail: Info@MapleLawnOrthodontics.com Website: www.MapleLawnOrthodontics.com

FROM BALTIMORE CITY:
Take I-95 S toward Washington – go 16.9 miles
Take Exit # 35 B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.0 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM CATONSVILLE:
Take Baltimore National Pike (US-40 W) – 4.4 miles
Take Left ramp onto US-29 S toward Columbia – go 9.1 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM CLARKSVILLE:
Take MD-32 E – go 2.6 miles
Take Exit # 17/Cedar Lane/Pindell School Road onto Sanner Road – go 2.0 miles
Continue onto Maple Lawn Blvd – go 0.6 miles
Make a Left into the parking Lot

FROM COLUMBIA/ELLICOTT CITY:
Take Columbia Pike (US-29 S) – go 3.5 miles (From Columbia) or go 7.4 miles (From Ellicott City)
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM FAIRFAX, VIRGINIA:
Take I-495 E toward Bethesda/Silver Spring/Baltimore
Take I-95 N towards Baltimore – go 10.4 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM GREENBELT/COLLEGE PARK:
Take I-95 N towards Silver Spring/Baltimore – go 13.3 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM LAUREL:
From Main Street, take MD-216 – go 3.9 miles
Bear Left on Scaggsville Road (MD-216 W) go 0.5 miles
Turn Right on Maple Lawn Blvd – 0.9 miles
Make a Right before the Red Brick Bld., onto the Parking Lot

FROM OLNEY/HIGHLAND:
Take MD-108 E (Olney Sandy Spring Road) – go 5.0 miles
Turn Right on Scaggsville Road (MD-216) – go 3.1 miles
Turn Left on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bldg., onto the Parking Lot

FROM ROCKVILLE/GAITHERSBURG/GERMANTOWN:
Take I-270 S – towards Capital Beltway (I-495)
Merge onto I-495 E – go 5.4 miles
Take I-95 N towards Baltimore – go 10.4 miles
Take Exit # 35B/Scaggsville onto Scaggsville Road (MD-216 W) – go 3.3 miles
Turn Right on Maple Lawn Boulevard – go 0.9 miles
Make a Right before the Red Brick Bldg., onto the Parking Lot

FROM TOWSON:
Take I-83 S towards Baltimore
Continue on I-695 W toward Pikesville/Washington – go 2.3 miles
Continue on I-695 S – go 7.7 miles
Take exit # 16B-A/Local Traffic/Frederick onto I-70 W toward # 16A/Frederick – go 4.3 miles
Take Left exit # 87A/Columbia/Washington onto US-29 S – go 10.7 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road onto Johns Hopkins Road toward Montpelier Road – Go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the parking Lot

FROM OUR SILVER SPRING OFFICE:
Take Columbia Pike (US-29 N) – go 7.2 miles
Take Exit # 15/Johns Hopkins Road/Gorman Road – go 0.4 miles
Go around the circle onto Johns Hopkins Road – go 0.9 miles
Bear Left on Maple Lawn Boulevard – go 0.6 miles
Make a Left into the Parking Lot