NEAL A. STUBBS, D.D.S.
929 Oakfield Drive
Brandon, FL 33511-4977

Phone 813-685-3511
Toll Free (800) 330-6325
Fax (813) 681-4879

NEW PATIENT REGISTRATION FORM

(FOR PATIENTS UNDER AGE 18)

The information provided is strictly confidential.

PATIENT INFORMATION

Patient's Legal Name:___________________________ **Preferred Name:** _______________________

Today's date: ____/____/____ **Birthdate:**_____/_____/_____ **Age:**_________ **Sex: M / F**

Address: ____________________________ **City, State, Zip:** __________________________________

Home phone: _(_____)_________________ **Email address:** __________________________________

Brothers/Sisters or Sons/Daughters (name/ages): ____

Hobbies/Interests: ____________________ **School/Grade:** ___________________________________

Previous orthodontic consultation? Yes / No If so, when/where? _______________________________

In your opinion, what is your orthodontic problem? ____

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

RESPONSIBLE PARTY INFORMATION

Father's Name: ________________________________ **Marital Status: S / M / W / D**

Address: _________________________________ **City, State, Zip:** _____________________________

Home phone: _(_____)__________________ **Cell/Work #:** _(_____)_____________________________

Social Security: _____-_____-_____ **Drivers License #:** ___________________ **Birthdate:** ___/___/___

Email address: _________________________________**Occupation:**_____________________________

Mother's Name: ________________________________ **Marital Status: S / M / W / D**

Address:__________________________________ **City,State,Zip:**_________________________

Home phone: _(____)___________________ **Cell/Work #:** _(_____)_____________________________

Social Security: _____-_____-_____ **Drivers License #:** __________________ **Birthdate:** ___/___/____

Email address: _________________________________**Occupation:**____________________________

If divorce is involved, who is the Custodial Parent? ____

May patient information be released to the non-custodial parent? Yes / No
Do you have orthodontic insurance coverage? Yes / No If yes, please fill out insurance form. Thanks!

Please complete both sides

NEW PATIENT REGISTRATION FORM
(FOR PATIENT UNDER AGE 18)

DENTAL INFORMATION

How does the patient feel about wearing "braces": ______________________________

Does anyone else in the family need orthodontics? Yes / No If yes who? ____________________

Dentist's Name: ____________________ Does the patient have regular checkups? Yes / No

Last Dental Exam: ____________________ Last Dental X-Rays:____________________

Other Dental Specialists: ____

Have you been satisfied with past dentistry? Yes / No If no, please explain ____________________

____

Does the patient currently have, or have had any of the following? (please circle)

Thumb/finger habit	Head/neck injury
Nail biting	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about? ____________________

____

MEDICAL INFORMATION

Physician's Name: ____________________ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen): ______________________________

Is the patient currently under medical care? Yes / No Where/When? ____________________

____

Is the patient currently taking medications? Yes / No Please list: ____________________

Has the patient ever been hospitalized? Yes / No Where/When? ____________________

Does the patient currently have, or have had any of the following? (please circle)

Adenoid removed	Drug history	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal/airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis A,B, or C	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal disease

EMERGENCY INFORMATION

Name:______________________________ Relationship to patient: ____________________
Address: ______________________________ City, State, Zip: ____________________
Home Phone:_(___)______________________________ Cell/Work #: _(___)____________________

***Signature: ______________________________ Today's Date: _______/_______/_______**