

ORTHODONTIC REGISTRATION

Gary J. Weitz, DMD
(201) 864-8400

Patient Information/Informacion Del Paciente:

Today's Date/Fecha: _____ Patient Age/Edad: _____ Sex: _____ Date Of Birth/Fecha de Nacimiento: _____
Patient Name/Nobre de Paciente: _____ SS# of Patient: _____
Address: _____ Apt#: _____ City/State: _____ Zip: _____
Home phone #: _____ Daytime phone#/Telefone de Dia: _____
Patient's Email Address: _____
Who May We Thank For This Referral/A quien podemos agradecer por la referencia _____
Name Of General Dentist/Nombre de Dentista General: _____ Tele: _____
Date Of Last Dental Check-up/Fecha de la Ultima Cita: _____ Cleaning/Limpesa: _____
Family Physician/Doctor General: _____ Tele: _____

Responsible Party Information/Información De Persona Encargado:

Complete Name of Patient's Mother and Father /Nombre Completo de Madre y Padre: _____
Address: _____ Apt#: _____ City/State: _____ Zip: _____
Home phone #: _____ Daytime phone#/Telefone de Dia: _____
Social Security #/Numero de Sueguro Social: _____ Email Address: _____

Dental Insurance Information/Información de Seguro Dental:

Social Security# of insured person/Numero Social de la Persona Con Seguro: _____
Name Of Insurance Card Holder/Nombre de Persona Con Seguro: _____ Birthdate: _____
Insurance Company Name/Nombre Del Seguro _____ Group#: _____ Local/Union: _____
Employer/Empleado: _____ Tele: _____

ORAL HYGIENE

Do You Floss/Usa Hilo Dental - Yes ___ No ___ (___ per week) Use Flouride Rinse- Yes ___ No ___ (___ per week)
How Often Do You Brush/Quantas Veses Cepilla Sus Dientes _____ per day/por dia
Is Your Toothbrush/Su Cepillo Es: Hard/Duro _____ Medium/Mediano _____ Soft/Suave _____

HAVE YOU EVER HAD OR DO YOU STILL/TIENE USTED O A TENIDO:

_____ Tonsils removed/Operado de las amigdalas(age/edad _____)	_____ Suck your thumb or fingers?/Chupa sus dedos?(age/edad _____)
_____ Treated for periodontal disease/Tratamiento de las encias	_____ Injury to your face/Eridas en su cara Explain _____
_____ Received hygiene instructions/Instruccion de limpieza dental	_____ Had braces/Tenido Tratamiento orthodontico (age/edad _____)
_____ Frequent blisters/Granos dentro de la boca	_____ Bite checks or lips/Morder sus labios
_____ Suck on a pasifier/Chupo tete (age/edad _____)	_____ Smoke tobacco in any form/Fumado tabacco de qual quera forma
_____ Take alcoholic beverages/Toma bebida alcohólico	_____ Allergic to any medication/Alergico a alguna medicina
_____ Have AIDS/Tiene Sida	_____ List _____
	_____ Breathing Problems or Asthma/Tiene problemas de respiro o Asthma

Is there any disease, condition not listed that you we should know?/Tien usted qual quier problema medico que bebe informar? _____

If ever any changes in my health or change in my medication, I will inform Dr. Weitz at the next appointment.

Signature of Patient (Parent /Guardian if minor) _____ Date _____

PLEASE PRESENT ALL DENTAL INSURANCE CARDS WHEN YOU COMPLETE THIS FORM.