Remington Orthodontics

409 Broad Street Suite 101B
Sewickley, PA 15143
(412) 741-7700

974 Beaver Grade Rd. Suite B
Moon Township, PA 15108
(412) 741-7700

Date: _____ / _____ / _____

Patient's Name: Mr. Mrs. Miss Dr. _____ Other: _____ Sex: M F
Home Address:_____ Home Phone: (____) _____
City, State, Zip: _____ Cell Phone: (____) _____
Patient Email: _____
Employer:_____ Work Phone: (____) _____
Social Security Number: _____ Date of Birth:____/____/____ Age: _____
Current School: _____ Hobbies/Interests: _____
Has the patient ever been in this office before? Yes No
Has any other member of your family had orthodontic care at this office? _____
If yes, name and relationship to patient: _____
Name of family dentist: _____ Did he/she refer you to our office? Yes No
If no, whom may we thank for referring you to our office?_____

Does the patient have or has he/she ever had:

Anemia ..... Yes No
Diabetes ..... Yes No
Epilepsy ..... Yes No
Hepatitis ..... Yes No
Asthma ..... Yes No
HIV+/AIDS ..... Yes No
Rheumatic Fever ..... Yes No
Heart Murmur ..... Yes No
Abnormal Blood Pressure ..... Yes No
Abnormal Bleeding From a Wound..... Yes No
Other Conditions: _____
Name of Physician: _____

Allergies to:

Penicillin ..... Yes No
Local Anesthetic ..... Yes No
List Other Medications You Are Allergic To:_____
_____
List Current Medications: _____
_____
_____

(If minor) Mother/ Mrs. Ms. Dr. _____Birthdate: _____ Marital Status S M D W Sep
Home Address:_____ Home Phone: (____) _____
City, State, Zip:_____ Cell Phone: (____) _____
Mother's Email: _____
Employer:_____ Work Phone:_____ Social Security #: _____

(If minor) Father/ Mr. Dr. _____Birthdate: _____ Marital Status S M D W Sep
Home Address:_____ Home Phone: (____) _____
City, State, Zip:_____ Cell Phone: (____) _____
Father's Email: _____
Employer:_____ Work Phone:_____ Social Security #: _____

(If adult) Spouse/Other _____Birthdate: _____ Marital Status S M D W Sep
Home Address:_____ Home Phone: (____) _____
City, State, Zip:_____ Cell Phone: (____) _____
Other Email: _____
Employer:_____ Work Phone:_____ Social Security #: _____

Who will pay this account? _____
Do you have dental insurance that may cover any part of orthodontic services? Yes No
If Yes – Please Complete Insurance Form
(signature of person completing form) _____ Date _____

Registration Form