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PATIENT REGISTRATION & INFORMATION

Date: _____

Last Name_____ First_____ Middle_____ Sex_____

Birthdate_____ Age____ Phone No._____ Patient's Email_____

Home / Mobile / Work

Preferred method for automated appointment reminders (please circle ONE): EMAIL / TEXT MESSAGE / PHONE CALL

Address – Street_____

City_____ State_____ Zip Code_____

Name of Dentist / Dental Office_____

Address_____ Phone No._____

Whom may we thank for referring you to our practice?_____

Adult Patient: Single_____Married_____Widowed_____Separated_____Divorced_____

Occupation_____Business Phone No._____

Minor Patient: Birth Weight_____ Present Weight_____ Height_____

School_____ Grade Level_____

Favorite Sports and Hobbies_____

Musical Instruments Played_____

Number of Brothers and Sisters_____ Ages_____

Other Family Members Treated_____

Responsible Party Information, *please list anyone who will be bringing the minor patient to appointments, responsible for financial matters, and responsible for treatment matters*

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

Full Name_____Sex_____ Relationship to Patient_____

Birthdate_____ Phone Number _____ Email_____

DENTAL (ORTHODONTIC) Insurance Coverage Yes_____ No_____

Insurance Co. Name_____ Policy/Group No._____

Subscriber's Name_____ **DOB:** _____ Relationship to Patient_____

Subscriber's SSN # _____ Subscriber's Insurance ID# _____

*** The Social Security Number is **required** if a member/subscriber ID number is not known.*

Subscriber's Address (if different than patient's address) _____

City_____ State_____ Zip Code_____

*The following information is **required** if the insurance plan is provided by an employer*

Company Name_____ Group No. _____

Company Phone No._____ Address _____

City_____ State_____ Zip Code_____

In Case We Cannot Reach You:

Name:_____ Phone No._____ Relationship to Patient_____

Please continue on the back side…

For the following questions circle **yes**, **no**, or **don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Minors Only

yes no dk/u Started teething very early or very late?
yes no dk/u Does patient have trouble following directions?
yes no dk/u Does patient have learning disabilities or need extra help with instructions?
yes no dk/u Are you taking birth control pills?
yes no dk/u Is patient sensitive, self-conscious?

Adults and Minors

yes no dk/u Birth defects of hereditary problems?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Kidney problems?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Problems of the immune system?
yes no dk/u Vision, hearing, tasting, or speech difficulties?
yes no dk/u Fainting spells, seizures, epilepsy, or neurologic problem?
yes no dk/u Do you have a poor and unhealthy diet?
yes no dk/u Sexually transmitted diseases? Please list:_____
yes no dk/u Chest pain, shortness of breath, or swelling ankles?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Currently have or ever had a substance abuse problem?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u High or low blood pressure?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Tires easily?
yes no dk/u AIDS or HIV positive?
yes no dk/u Eye, ear, nose, throat, tonsil, adenoid conditions?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Are you pregnant or expecting to become pregnant?
yes no dk/u Are there any mental health problems? Please list: _____
yes no dk/u Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?
yes no dk/u Cardiovascular problem, heart trouble, heart attack, angina, coronary insufficiency, arterlosclerosis, stroke, inborn heart defects, or rheumatic heart?
yes no dk/u Allergies or drug reactions? Please list: _____
yes no dk/u Are you taking medication, supplements, or non-prescription medicine? Please list:_____
yes no dk/u Operations/Surgical procedures/Hospitalizations for: _____
yes no dk/u Other physical problems or symptoms?_____
yes no dk/u Is the patient seeing any other health care professional? For_____

Dental History

Minors Only

yes no dk/u Does patient have trouble following directions?
yes no dk/u Removal of (baby) teeth that were not loose?
Onset of puberty (approximate age)_____

Adults and Minors

yes no dk/u Prior orthodontic treatment? When?_____
yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Thumb, finger, sucking habit? Until_____
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Concerned about spaced, crooked, protruding teeth?
yes no dk/u Has patient ever had periodontal (gum) treatment?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal disease, "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u History of speech problems?
yes no dk/u Difficulty chewing or opening jaw?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Any relative with similar tooth or jaw problems?
yes no dk/u Loose, broken, or missing restorations (fillings)?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of most recent dental examination_____ How often does patient brush?_____ Floss?_____

What is the patient's (or guardian's) primary concern? Why are you here today?_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Signature of patient/guardian **Printed Name** **Date**

Signature of Doctor **Date**

MEDICAL & DENTAL HISTORY UPDATE – Should be completed at least once a year. Are there any changes to your medical and dental history that we should be aware of? Please write "none" or explain:_____

Signature of patient/guardian **Printed Name** **Date**

Signature of Doctor **Date**