N T ______________________

ADULT PATIENT REGISTRATION

Date ________________________
Patient # ____________________

Patient's Name____ Phone ____________________
LAST FIRST MIDDLE

Address____
CITY STATE ZIP

Email (required for correspondence/reminders) ______________________________________

Preferred Name (if different)______________________ Birthdate______________ Age __________Sex M F
mo/day/yr

Occupation__________________ Employer______________________ Business Phone ____________________

When/Where is the best time to reach you?__________________________ Cell Phone ____________________

Email Address__________________________ Who may we thank for referring you? ____________________

Main Concern____

Has patient seen another orthodontist (circle) YES NO If yes, name______________________________

Has any immediate family member been to our office before regarding orthodontics? (circle) YES NO If yes, who? ______________

Family dentist______________________ City______________ Date of last dental check-up __________

Person(s) responsible for this account____________________________________ Phone____________________

Address (if different)____

Occupation__________________ Employer______________________ Business Phone ____________________

Dental insurance (circle) YES NO If yes, company______________________ Cell Phone ____________________

Medical insurance (circle) YES NO If yes, company ______________________________________

FOR INSURANCE PURPOSES: Name of Policy Holder______________________ ID #______________________

Social Security # of Policy Holder____

MEDICAL/DENTAL HISTORY

Family Physician______________________ Date of last physical______________ General Health ______________

Is patient under a physician's care? YES ❏ NO ❏ If so, for what? ______________________________

List any medications now being taken:__________________________ For what reason? ____________________

List any allergies, drug or latex sensitivity: ______________________________________

Does patient vomit, gag, or faint easily? YES ❏ NO ❏ Explain ______________________________

Has patient been diagnosed or treated for any of the following, indicate by circling appropriately:

Rheumatic Fever	YES	NO	Blood Disorders	YES	NO	Lung Disorders	YES	NO	Bone Disorders	YES	NO
Heart Disease	YES	NO	Anemia	YES	NO	Asthma	YES	NO	Arthritis	YES	NO
Abnormal Blood Pressure	YES	NO	Hepatitis	YES	NO	Diabetes	YES	NO	Other	YES	NO
Heart Murmur	YES	NO	AIDS/HIV Pos.	YES	NO	Seizures	YES	NO	Explain ____________		

Does Patient Require Antibiotic Pre-Medications? YES NO Explain: ______________________________

Does the patient experience headaches or neckaches, especially under stress?	YES	SOMETIMES	NO
Does the patient grind or clench teeth?	YES	SOMETIMES	NO
Has the patient had any jaw or head injuries?	YES		NO
Does the patient experience any clicking, popping or pain while chewing or yawning?	YES	SOMETIMES	NO
Has the patiend experienced any episodes of jaws locking in the open or closed positions?	YES	SOMETIMES	NO
Has the patient ever consulted anyone regarding a jaw problem?	YES		NO
Have any teeth been injured due to an accident or fall?	YES		NO
Have you ever been treated for periodontal (gum) disease?	YES		NO
Is there any reason the patient may have problems with orthodontic treatment?	YES		NO
Is the patient/parent aware that appointments will infringe on school/work time?	YES		

SIGNATURE______________________________________ **DATE**____________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________

I have reviewed the above information and noted any necessary changes.

Signature ______________________

Date ______________________