



NEW PATIENT REGISTRATION FOR OUR ADULT PATIENTS

Last Name First Name Middle Initial Preferred Name
Date of Birth Age Gender: M F Social Security Number
Home Address City State Zip
Home Phone Work Phone Cell Phone
Family Dentist Family Physician Email
Employer Occupation
Marital Status: Married Single Divorced Widowed
Children:
Name Birthdate Name Birthdate
Name Birthdate Name Birthdate
Emergency Contact Person
Who/Whom may we thank for referring you to our office?

Family Information

Spouse's Name Date of Birth Social Security Number
Spouse's Address City State Zip
Home Phone Work Phone Cell Phone
Employer Occupation

Responsible Party Information

Who is the person responsible for the patient's account? Self Spouse Other (please see below for other)
Other's Name Date of Birth Social Security Number
Other's Address (if different from patient's) City State Zip
Home Phone Work Phone Cell Phone
Employer Relationship to Patient

Orthodontic/Dental Insurance Information

Primary Dental Insurance:

Insured's Name Relationship to Patient
Social Security Number Date of Birth Employer
Dental Insurance Carrier Group/ID Number

Secondary Dental Insurance:

Insured's Name Relationship to Patient
Social Security Number Date of Birth Employer
Dental Insurance Carrier Group/ID Number

Health Questionnaire

Medical History

- Yes No Is the patient in good health? If no, please explain _____
- Yes No Is the patient currently being treated by a physician? If yes, please explain _____
- Yes No Any previous hospitalization or serious illness? If yes, please explain _____
- Yes No Is the patient allergic to latex?
- Yes No Is the patient allergic to any medications? If yes, please list: _____
- Yes No Is the patient taking any medications? If yes, please list: _____

Does the patient now, or have they ever had a history of any of the following (Mark Y or N):

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N -Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N -Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N -Joint Replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N -Lung Disease | <input type="checkbox"/> Y <input type="checkbox"/> N -Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Severe Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N -ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N -Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Easy Bruising | <input type="checkbox"/> Y <input type="checkbox"/> N -Nose Bleeds | <input type="checkbox"/> Y <input type="checkbox"/> N -Eye Problems/Glaucoma |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Kidney Problems | <input type="checkbox"/> Y <input type="checkbox"/> N -Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N -Congenital Heart Defect |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Yellow Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> N -High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N -Dizziness or Fainting |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Ear Problems | <input type="checkbox"/> Y <input type="checkbox"/> N -Speech Problems | <input type="checkbox"/> Y <input type="checkbox"/> N -Venereal Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Heart Condition | <input type="checkbox"/> Y <input type="checkbox"/> N -Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N -Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Hepatitis type ____ | <input type="checkbox"/> Y <input type="checkbox"/> N -Low Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N -Convulsions/Seizures |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Sinus Problems | <input type="checkbox"/> Y <input type="checkbox"/> N -Swallowing Problems | <input type="checkbox"/> Y <input type="checkbox"/> N -HIV Positive |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Bisphosphonate Tx | <input type="checkbox"/> Y <input type="checkbox"/> N -Tumor/Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N -Bone Disorders |

Dental History

Does the patient have a chief concern about their teeth? _____

Date of most recent dental examination: _____

- Yes No Has the patient had a previous orthodontic exam? If so, when _____
- Yes No Has the patient had previous orthodontic treatment? If so, when _____
- Yes No Has the patient's adenoids and/or tonsils been removed?

Does the patient now, or have they every had a history of any of the following (Mark Y or N):

- | | | |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N -Injury to the Teeth/Jaws | <input type="checkbox"/> Y <input type="checkbox"/> N -Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N -Joint Clicking/Popping |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Grinding | <input type="checkbox"/> Y <input type="checkbox"/> N -Joint Pain | <input type="checkbox"/> Y <input type="checkbox"/> N -Snoring |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Sleep Apnea | <input type="checkbox"/> Y <input type="checkbox"/> N -Gum Disease | <input type="checkbox"/> Y <input type="checkbox"/> N -Jaw Growth Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Finger/Thumb Sucking | <input type="checkbox"/> Y <input type="checkbox"/> N -Mouth Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N -Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Headaches/Earaches | <input type="checkbox"/> Y <input type="checkbox"/> N -Tongue Thrust | <input type="checkbox"/> Y <input type="checkbox"/> N -Missing Teeth |
| <input type="checkbox"/> Y <input type="checkbox"/> N -Sensitive Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N -Tobacco Use | <input type="checkbox"/> Y <input type="checkbox"/> N -Extra Teeth |

Please elaborate on any items that were marked: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information not disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I authorize the Orthodontist to share this patient's treatment information with the collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

Signature of patient, guardian or responsible party

Date

Doctor's Initial