

Date: ____/____/____

ADULT REGISTRATION FORM



PATIENT INFORMATION

Mr. Ms. Miss Dr.

First _____ M.I. _____ Last _____

Home Address Street _____ City _____ State _____ Zip _____

Telephone Home _____ Mobile _____ Office _____

Male Female

Email Address _____ Date of Birth _____ Social Security Number _____

Employer _____ Business Address _____

Married? Spouse's Name _____

Yes

No Employer _____ Business Address _____

Business Phone _____

In case of emergency, contact: _____ Telephone _____

Who may we thank for this referral? _____

Reason for consultation: _____

BILLING

Name of person assuming financial responsibility: _____

Billing Address Street _____ City _____ State _____ Zip _____

E-mail Address _____ Telephone _____

Do you have orthodontic insurance coverage? Yes No
 If DUAL COVERAGE, make sure to complete both primary and secondary carrier sections.

INSURANCE

Primary Insurance Company Name

Address

Telephone

Employer

Group Number

Social Security Number Date of Birth

Secondary Insurance Company Name

Address

Telephone

Employer

Group Number

Social Security Number Date of Birth

YOUR HEALTHCARE PROVIDERS

MEDICAL HISTORY

Physician's Name	Telephone	Date of Last Visit	
Address	City	State	Zip

- Yes No
- Are you in good health?
- Have you ever been under the care of a physician for an illness?
- Do you have any history of major illness?
- Have you ever been hospitalized?
- Are you taking any drugs or medications? (List below under Additional comments)
- Are you allergic to any medication? (List below)
- Have you had any unusual reaction to a medication?
- Have you taken any diet medications (i.e., Fen-Fen)?
- Have you taken bisphosphonates (i.e., Fosamax, Actonel, Zometa)?
- Do you take sedatives, tranquilizers, sleeping pills or medicine to relax?
- Do you have trouble sleeping?
- Do you snore when sleeping?
- Have your tonsils and/or adenoids been removed? If yes, at what age?
- If female: Are you pregnant?
- Are you taking birth control pills?

Additional explanations or comments:

Check whether you have/had any of the following conditions:

- | | |
|--|--|
| <input type="radio"/> Heart Problems | <input type="radio"/> Endocrine Problems |
| <input type="radio"/> Hepatitis | <input type="radio"/> Epilepsy |
| <input type="radio"/> Kidney Problems | <input type="radio"/> Bone Disorders |
| <input type="radio"/> Rheumatic Fever | <input type="radio"/> Arthritis |
| <input type="radio"/> Lung Problems | <input type="radio"/> Prolonged Bleeding |
| <input type="radio"/> Nervous Problems | <input type="radio"/> Anemia |
| <input type="radio"/> Liver Problems | <input type="radio"/> Asthma |
| <input type="radio"/> Psychiatric Care | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Allergies | <input type="radio"/> Implants |
| <input type="radio"/> Malignancies | <input type="radio"/> Diabetes |

Are you allergic or have reacted adversely to:

- Yes No
- Local anesthetics
- Penicillin/other antibiotics
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin
- Codeine or other narcotics
- Latex
- Other: _____

DENTAL HISTORY

Dentist's Name	Telephone	Date of Last Visit	
Address	City	State	Zip

Date of last dental exam: _____

- Yes No
- Have you previously consulted an orthodontist?
- Have you ever had orthodontic treatment or been treated for a bad bite?
- Is there clicking, popping or grating noise from your jaw when chewing?
- Do you clench or grind your teeth?
- Has there been any treatment for problems of your jaw joint or for facial muscle spasms?
- Have there been any injuries to your face, mouth or teeth?
- Have you had any previous unpleasant dental or orthodontic experiences? (Specify below)

Additional explanations or comments:

- Yes No
- Is there numbness or tingling associated with your mouth or face?
- Do your gums bleed on brushing or flossing? How many times/week do you floss? _____
- Have you ever had periodontal (gum) disease?
- Do you have any speech problems?
- Have you been informed of any missing or extra teeth?
- Are you a mouth breather?
- Do you use a mouth guard or plastic splint?

Signature: _____

Date: _____