

Patient Information

A

Date _____

Patient's Name _____ Sex: M or F
Last First Middle

Address _____
Street City State Zip

How long at this address? _____ If less than 3 years - list previous address:

Previous Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ SS# _____
Street City State Zip

Employer _____ Occupation _____ Years Employed _____ Work Phone _____

Marital Status: Single / Married / Divorced / Widowed / Separated (Circle One)

Spouse's Name _____ Birthdate _____ Age _____ SS# _____
Street City State Zip

Employer _____ Occupation _____ Years Employed _____ Work Phone _____

Children: _____ Birthdate _____ Age _____ Sex: M or F
 _____ Birthdate _____ Age _____ Sex: M or F
 _____ Birthdate _____ Age _____ Sex: M or F

List any Family Members who have been or are in treatment in our office: _____

General Dentist: _____

Who may we thank for referring you to our office? _____

Hobbies _____

Dental Insurance Information

a b c

Insured's Name _____ SS# _____
Last First Middle

Relationship to Patient _____

Insured's Employer _____ Work Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____

Insurance Phone No. _____

Do you have dual coverage? Yes or No If Yes:

Insured's Name _____ SS# _____
Last First Middle

Relationship to Patient _____

Insured's Employer _____ Work Phone _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____

Insurance Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient _____ Home Phone _____

Address _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Signature _____

OFFICE USE ONLY - UPDATES (Date and Initial) _____

(Please complete the reverse side of this form)

Dental History

Name of your general dentist _____
When did you last visit your dentist? _____
Have you consulted with or been treated by an orthodontist previously? _____
Why are you seeking an orthodontic consultation? _____

Please respond to the following:

- Y or N 1 - Do you clench or grind your teeth? _____
- Y or N 2 - Do you have a history of thumb or finger sucking? Until what age? _____
- Y or N 3 - Have you ever had a severe head, neck or facial injury? Please explain _____

- Y or N 4 - Do you play any musical (wind) instruments? If yes, what? _____
- Y or N 5 - Have you previously been treated for a TMJ problem? If so, please describe: _____

- Y or N 6 - Do you have pain or noises in or about the ears, temples or cheeks? If yes, please describe: _____

- Y or N 7 - Do you have difficulty opening your mouth or does your jaw get locked? If yes, please describe: _____

- Y or N 8 - Do you experience frequent headaches? _____

Medical History

Name of family physician _____
Are you currently being treated for an injury or illness: Y or N If yes, please explain: _____

List medications that you are currently taking: _____

List any drug sensitivities _____
Are you allergic to anything other than medications listed above? Y or N If yes, what? _____

Please circle if you have or have had any of the following:

- | | | |
|-------------------------------|---------------------------|------------------------------------|
| Y or N Arthritis | Y or N Heart Disease | Y or N Frequent Colds or Flu |
| Y or N Anemia | Y or N Tuberculosis | Y or N Hearing Problems |
| Y or N Blood Disease | Y or N Diabetes | Y or N Tonsillitis/Adentitis |
| Y or N Prolonged Bleeding | Y or N Endocrine Problems | Y or N Tonsils Removed: Age _____ |
| Y or N Hepatitis | Y or N Bone Disorders | Y or N Adenoids Removed: Age _____ |
| Y or N AIDS Antibody Positive | Y or N Epilepsy | Y or N Asthma |
| Y or N Jaundice | Y or N Herpes | Y or N Mouthbreathing: _____ |
| Y or N Rheumatic Fever | Y or N A.D.D. | Y or N Emotional Problems |
| Y or N Kidney Disease | Y or N Other _____ | |

I authorize X-rays and Photos to be taken for diagnostic purposes _____
Signature

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Comprehensive Patient Registration Record
All Information Listed is
STRICTLY CONFIDENTIAL