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Acct. No. ________

PATIIENT REGISTRATION HISTORY-**ADULT**

☐Mr. ☐Mrs. Date ____/____/____

☐Ms. ☐Dr. ____ ☐Male ☐Female D.O.B. ____/____/____
First Middle Last

Home Address ____
Street City State Zip

Home Phone ___________________________ Cell_________________________ E-Mail ____________________

Business Phone ___________________ Insurance Company ________________________ Employer______________

Spouse's Name_____________________________ D.O.B. ____/____/____ Insurance Company_________________

Patient's Social Security No. ____-____-____ Spouse's Social Security No. ____-____-____

Referred By? ____

MEDICATIONS CURRENTLY TAKING:____
____

PLEASE CHECK YES OR NO TO THE FOLLOWING:

YES	NO	
☐	☐	Has patient had a physical exam in the past year?
☐	☐	Is patient presently under a physician's care?
☐	☐	Has Patient ever been hospitalized?
☐	☐	Is patient taking any pills, medications or drugs?
☐	☐	Has patient ever had major surgery?
☐	☐	Has patient had any reactions to any medications?
☐	☐	Has patient had his/her tonsils and/or adenoids removed?
☐	☐	Does patient experience fainting or dizzy spells?
☐	☐	Does patient have too high or too low blood pressure?

HAS PATIENT BEEN DIAGNOSES OR TREATED FOR:

Yes	No		Yes	No	
☐	☐	Heart problems	☐	☐	Hepatitis
☐	☐	Rheumatic fever	☐	☐	Diabetes
☐	☐	Lung problems	☐	☐	Malignancies
☐	☐	Liver problems	☐	☐	Anemia
☐	☐	Endocrine problems	☐	☐	Arthritis
☐	☐	Prolonged Bleeding	☐	☐	Bone
☐	☐	Tuberculosis	☐	☐	Asthma
☐	☐	Herpes	☐	☐	Aids

PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

☐Aspirin ☐Codeine ☐Penicillin ☐Sulfa ☐Latex ☐Metals

☐ Other _________________________

Dr. Notes:

MEDICAL ALERT
Yes No

Are there any other medical problems I should be aware of? ____

DENTAL HISTORY

DENTIST NAME ________________________________ PHONE ___________________________ DATE OF LAST CLEANING ____/____/____

Yes	No	
☐	☐	Has patient ever had orthodontic consultation or treatment?
☐	☐	Has patient been informed of any missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Has a family member had orthodontic treatment? Who?__________________________________
☐	☐	Does patient breathe predominately trough his/her mouth?
☐	☐	Does patient have any speech problems?
☐	☐	Does patient now suck his/her thumb or finger?
☐	☐	Does patient grind or clench his/her teeth
☐	☐	Does patient have pain or clicking of the jaw?
☐	☐	Has patient ever had any teeth injured by due to an accident?
☐	☐	Has patient ever had pains in the face?
☐	☐	Has patient ever had severe jaw or head injury?
☐	☐	Does patient want his/her teeth straighten?
☐	☐	Does patient's gums bleed when brushing or flossing?

Are there any other dental/orthodontic problems I should be aware of? _____________________________________

Patient's signature____ Date ____/____/____