



Welcome

Adult New Patient Registration

(For Patients Over Age 18)

Today's Date _____

Patient Name _____ Prefer to be called _____ Sex _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Occupation _____ Employed By _____

Spouse's Name _____ Work Phone _____

Occupation _____ Employed By _____

Who may we contact in case of emergency? _____ Phone _____

Family Dentist _____ Family Physician _____

In your opinion, what is your orthodontic problem? _____

Who may we thank for recommending you for your appointment? _____

Person responsible for account _____

Social Security # _____ Birthdate _____ Age _____ Sex _____

Address _____

City, State, Zip _____

Do you have orthodontic insurance coverage? No Yes, Company _____

Group Number _____ Phone/Contact _____

HEALTH QUESTIONNAIRE

Today's Date _____

Patient Name _____ Birthdate _____

Date of last dental visit or check-up _____

Have you ever had the following dental treatment?

Orthodontics, Date _____, by Dr. _____
Periodontal treatment (gum treatment)
Mouthguard or splint therapy for jaw joint problems
Jaw surgery to change your bite or to correct jaw joint

Do you have or have you had any of the following oral conditions?

Clenching or grinding	Bleeding gums	Sensitive Teeth
Jaw joint sounds or pain	Bad Breath	Poorly functioning teeth
Jaw gets stuck open or closed	Food wedging between teeth	Swelling or lumps in the mouth
Pain in jaw or face	Injury or blow to the chin or jaw	Mouth Breathing
Pain when opening or closing mouth	Dry Mouth	Oral habits (thumb sucking, etc)
Pain around ear	Discolored teeth	Tobacco use

Do you have or have you had any of the following medical conditions?

Rheumatic Fever	Congenital heart lesions / murmur	Osteoporosis
Diabetes	Anemia	Asthma
Sleep Apnea	Kidney problems	Tuberculosis
Arthritis (any type)	Heart condition	Severe Headaches
Liver disease	High blood pressure	Dizziness or Fainting
Hepatitis type _____	Low blood pressure	Convulsions or seizure
Yellow jaundice	Ear problems	Sinus problems
Chronic Pain Disorders	Eye problems	Swallowing problems
Easy bruising	HIV positive	Speech problems

Are you currently under a physician's care? If yes, describe _____ yes no

Has patient ever been hospitalized or had any serious illness? If yes, describe _____ yes no

Does the patient have any drug allergies? If yes, list medications _____ yes no

Is the patient allergic to latex? yes no

Is the patient taking any medication? If yes, list medications _____ yes no

Have you ever taken Bisphosphonates to treat osteoporosis or other bone related diseases yes no

Female patients – could patient possibly be pregnant at the present time? yes no

Patient signature _____ Date _____

Notes:
