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PATIENT REGISTRATION
HISTORY - ADULT

DATE _____/_____/_____

☐ MR. ☐ MRS.
☐ MS. ☐ DR. _____ ☐ MALE ☐ FEMALE
FIRST MIDDLE LAST

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ E-MAIL _____ CELL/PAGER _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MARRIED
☐ YES ☐ NO SPOUSE'S NAME _____ SPOUSE'S OCCUPATION _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT _____

ADDRESS _____ MEDICAL ID# _____
(STREET) (CITY) (STATE) (ZIP)

YES	NO	
☐	☐	Have you undergone a physical exam in the past year?
☐	☐	Are you presently under a physician's care?
☐	☐	Have you ever had a major surgery?
☐	☐	Have you ever been hospitalized?
☐	☐	Are you taking any pills, medications or drugs?
☐	☐	Are you allergic to novocaine or penicillin?
☐	☐	Have you had any unusual reaction to any medication?
☐	☐	Have you had tonsils and/or adenoids removed?
☐	☐	Do you have fainting or dizzy spells?
☐	☐	Do you have a too high or low blood pressure?

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

Have you ever been diagnosed or treated for the following?

YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Hepatitis
☐	☐	Kidney Problems	☐	☐	Rheumatic Fever
☐	☐	Lung Problems	☐	☐	Emotional Problems
☐	☐	Liver Problems	☐	☐	Malignancies
☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Diabetes	☐	☐	Bone Problems
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding
☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Asthma

_____ IF YES, PLEASE EXPLAIN _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

WHAT IS THE MAJOR CONCERN ABOUT YOUR TEETH? _____

_____

DATE OF LAST CLEANING _____ ANY PENDING WORK? _____

YES	NO	
☐	☐	Have you ever had previous orthodontic consultation or treatment?
☐	☐	Have you ever been informed of any extra or missing teeth?
☐	☐	Have any permanent teeth been removed by extraction?
☐	☐	Has any family member had orthodontic treatment? Who? _____
☐	☐	Have you ever sucked your thumb or finger?
☐	☐	Do you breath predominantly through the mouth?
☐	☐	Do you have any speech problems?

YES	NO	
☐	☐	Do you grind or clench your teeth?
☐	☐	Do you have pain or clicking of the jaw joint?
☐	☐	Have any teeth been injured or chipped due to an accident?
☐	☐	Do you ever have pains in the face or head?
☐	☐	Have you ever had severe jaw or head injury?
☐	☐	Do your gums bleed on brushing or flossing?
☐	☐	Are you concerned about the appearance of your teeth?
☐	☐	Do you want your teeth straightened?

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

I UNDERSTAND THAT WHEN APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED FOR FINANCIAL ARRANGEMENTS.

Patient Signature _____ Date _____