Orthodontic Registration Form

Thank you for taking the time to complete this form before your first visit. We look forward to meeting you!

Adult Patient Information

Name (First, M.I., Last Name) _____ Preferred Name _____

Birthday _____ Age _____ ☐ Female ☐ Male Sex _____ Email _____

Mailing Address (Street, City, State, Zip) _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Employer _____ Occupation _____ #Years _____

Appointment Reminders ☐ Yes ☐ No Send Apointment Reminders to ☐ Text ☐ Email

Has any other member of the family been treated in our office? If yes, who? _____

Dental/Orthodontic Insurance Company *(Please provide a copy of your insurance card)* _____ SSN _____

Hobbies _____

Dentist _____ Date of Last Dental Visit _____

Please Tell Us How You Heard About Our Practice ☐ Dentist ☐ Friend ☐ Other _____

What would you like orthodontic treatment to accomplish? _____

Has another orthodontist been consulted or previous orthodontic treatment been provided? ☐ Yes ☐ No

If yes, what work has been completed and by whom? _____

Spouse Information

Name (First, M.I., Last Name) _____ ☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms. ☐ Other _____ Title

Preferred Name _____

Birthday _____ Age _____ ☐ Female ☐ Male Sex _____ Email _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Employer _____ Occupation _____ #Years _____

Mailing Address (If Different) _____ Dental/Orthodontic Insurance Company *(Please provide a copy of your insurance card)* _____

Emergency Contact Information

Name (First, M.I., Last Name) _____ Relationship to Patient _____

Address (Street, City, State, Zip) _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Dental History

Check if you have had any of the following:

- ☐ Bleeding Gums
- ☐ Blisters On Lips/Mouth
- ☐ Dry Mouth
- ☐ Extracted Permanent Teeth
- ☐ Finger/Thumb Habit
- ☐ Grinding Teeth
- ☐ Gums Sore/Swollen
- ☐ Injuries To Teeth/Jaw
- ☐ Injuries To Face/Head
- ☐ Jaw Clicking/Popping (Bilateral, Right Side, Left Side)
- ☐ Jaw Lock Open/Closed
- ☐ Jaw Pain/Tenderness (Bilateral, Right Side, Left Side)
- ☐ Lip/Cheek Biting
- ☐ Mouth Breathing
- ☐ Periodontal Treatment
- ☐ Speech Problems
- ☐ Tongue Habit/Thrust

How often do you brush? _____ How often do you floss? _____

Hand used to brush teeth ☐ Left ☐ Right How would you rate your overall dental health? Poor < 0 1 2 3 4 5 > Great

Additional Comments: _____

Medical History Form

Check if you have had any of the following:

- ☐ AIDS/HIV+
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatment
- ☐ Coughing-Persistent
- ☐ Cough Up Blood
- ☐ Diabetes
- ☐ Emotion, Sensory, Or Developmental Issues
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequent Headaches Or Migraines
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Thyroid Problems
- ☐ Tobacco Use
- ☐ Tonsillitis
- ☐ Tonsils Removed
- ☐ Tuberculosis (TB)
- ☐ Shortness Of Breath

Sleep Questionnaire

Previous diagnosis of Obstructive Sleep Apnea? ☐ Yes ☐ No Do you snore loudly? ☐ Yes ☐ No

Do you often feel tired, fatigued, or sleepy during the daytime? ☐ Yes ☐ No

Have you ever stopped breathing or choked/gasped during sleep? ☐ Yes ☐ No

Are you being treated for high blood pressure? ☐ Yes ☐ No

General Health Information

Are you under the care of a physician? ☐ Yes ☐ No If yes, please describe: _____

Do you smoke or chew tobacco? ☐ Yes ☐ No Females: Is it possible you are pregnant? ☐ Yes ☐ No

Have you ever taken a bisphosphonate medication, such as: Aclasta, Actonel, Actonel+Ca, Aredia, Ateliva, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax +D, Reclast, Skelid, or Zometa? ☐ Yes ☐ No Additional Comments: _____

Do you have an allergy or sensitivity to Latex, Metals, or Plastics? ☐ Yes ☐ No

Have you ever required antibiotics (Pre-medication) prior to a dental visit? ☐ Yes ☐ No

How would you rate your overall physical health? Poor < 0 1 2 3 4 5 > Great

Medications: Please list ANY & ALL medications you are currently taking. _____

Allergies: Please list ANY & ALL known allergies. _____

I understand the information provided today is correct to the best of my knowledge. This information will be held in the strictest confidence, and I understand it is my responsibility to inform this office of any changes in my child's medical status. I understand that it is the office's policy to scan and store original documents in electronic form. I acknowledge that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

_____ _____

Patient Signature Date