Patient Registration

Patient's Name: LAST FIRST MIDDLE NICKNAME

Gender: female

Address: STREET CITY STATE ZIP

HOME PHONE BIRTH DATE AGE SSN

Siblings:

How did you hear of our office?

Responsible Party Information

Name:

LAST FIRST MIDDLE

MARITAL STATUS HOME PHONE WORK PHONE

Residence:

STREET CITY STATE ZIP

Mailing Address:

STREET CITY STATE ZIP

How Long at this Address?

Previous Address (if less than 3 years)

STREET CITY STATE ZIP

EMPLOYER OCCUPATION YEARS EMPLOYED

Spouse's Name

LAST | FIRST | MIDDLE

RELATIONSHIP TO PATIENT

EMPLOYER | OCCUPATION | YEARS EMPLOYED

SSN | BIRTHDATE | WORK PHONE

Insurance Information

INSURED'S NAME | INSURED'S SSN

INSURED'S EMPLOYER

INSURANCE COMPANY | GROUP NUMBER | LOCAL NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE PHONE NUMBER

DO YOU HAVE DUAL COVERAGE? no

INSURED'S NAME | INSURED'S SSN

INSURED'S EMPLOYER

INSURANCE COMPANY | GROUP NUMBER | LOCAL NUMBER

INSURANCE COMPANY ADDRESS

INSURANCE PHONE NUMBER

DO YOU HAVE DUAL COVERAGE?

Medical History

Family Physician:
Phone Number:
Date of Last Visit:

Abnormal Bleeding / Hemophilia	no		
Anemia	no		
Arthritis		no	
Asthma or Hayfever	no		
Bone Disorders		no	
Congenital Heart Defect	no		
Diabetes		no	
Dizziness	no		
Epilepsy		no	
Gastrointestinal Disorders	no		
Heart Problems		no	
Heart Murmur	no		
Hepatitis / Liver Problems		no	
Herpes	no		
High Blood Pressure		no	
HIV + / AIDS	no		
Kidney Problems		no	
Nervous Disorders	no		
Pneumoia		no	
Prolonged Bleeding	no		
Radiation / Chemotherapy		no	
Rheumatic Fever	no		
Tuberculosis		no	
Tumor or Cancer	no		

Are there any medical conditions we have not discussed that you feel we should be aware of?

Dental History

General Dentist:
Date of Last Visit:
Phone Number:

Are you presently in any dental pain	no		
Have you ever experienced any unfavorable reaction to dentistry ?		no	
Have you ever lost or chipped any teeth?	no		
Have there been any injuries to face, mouth or teeth?		no	
Is any part of your mouth sensitive to temperature or pressure ?	no		

Do your gums bleed when you brush ?	no
Do you have any type of thumb or tongue habit ?	no
Are you a mouth breather	no
Have you ever seen an orthodontist ?	no
Has anyone in the family received orthodontic treatment ?	no
How did they feel about the result ?	
What is your attitude toward orthodontic treatment ?	
Do your teeth or jaws ever feel uncomfortable when you awake in the morning?	no
Are you aware of your jaw clicking or popping ?	no
Are you aware of clenching your teeth during the day ?	no
Have you ever been told that you grind your teeth ?	no
Do you have "tension" headaches ?	no
Have you ever experienced chronic ringing in your ears ?	no
Are you aware some appointments will be during school / work hours ?	no