



Patient Registration

Patient's Name:

LAST

FIRST

MIDDLE

NICKNAME

Gender:

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

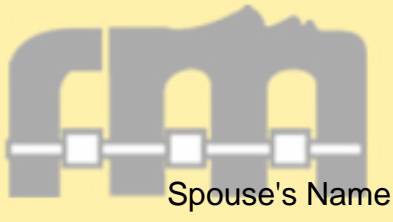
STATE

ZIP

EMPLOYER

OCCUPATION

YEARS EMPLOYED



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?

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

Anemia

Arthritis

Asthma or Hayfever

Bone Disorders

Congenital Heart Defect

Diabetes

Dizziness

Epilepsy

Gastrointestinal Disorders

Heart Problems

Heart Murmur

Hepatitis / Liver Problems

Herpes

High Blood Pressure

HIV + / AIDS

Kidney Problems

Nervous Disorders

Pneumoia

Prolonged Bleeding

Radiation / Chemotherapy

Rheumatic Fever

Tuberculosis

Tumor or Cancer

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

Have you ever experienced any unfavorable reaction to dentistry ?

Have you ever lost or chipped any teeth?

Have there been any injuries to face, mouth or teeth?

Is any part of your mouth sensitive to temperature or pressure ?



Do your gums bleed when you brush ?
Do you have any type of thumb or tongue habit ?
Are you a mouth breather
Have you ever seen an orthodontist ?
Has anyone in the family received orthodontic treatment ?

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?
Are you aware of your jaw clicking or popping ?
Are you aware of clenching your teeth during the day ?
Have you ever been told that you grind your teeth ?
Do you have "tension" headaches ?
Have you ever experienced chronic ringing in your ears ?
Are you aware some appointments will be during school / work hours ?