PATIENT REGISTRATION

Patient's Name ______________________

Employed by: ______________________
Street Address ______________________
City & State ______________________
Zip Code ______________________
Business Phone ______________________

Prefers to be called ______________________

Age_____ Birthdate______________ Sex____

Dentist ______________________
Date of Last Visit ______________________

Address:
Street or Route ______________________
City & State ______________________
Zip Code ______________________

Physician ______________________

Phone Number ______________________
Cell Phone ______________________
Phone # for reminder calls______________________
Email for reminders ______________________

Email ______________________

Whom may we thank for referring you to our office?______________________

What is/are your concerns regarding your bite/teeth? ______________________

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Has any family member been treated by our office? ______________________

Name of Family member treated ______________________ Relationship______________

Has the patient had any of the following: Circle Yes or No

1. Rheumatic Fever.. Yes No
2. Heart Condition.. Yes No
3. Diabetes.. Yes No
4. Epilepsy.. Yes No
5. Hemophilia (Bleeding Disorder).. Yes No
6. Allergies.........Allergic to what?______________________.. Yes No
7. Drug Reaction ...Which drug?______________________.. Yes No
8. Hepatitis.. Yes No
9. Venereal Disease.. Yes No
10. Aids or Related HIV.. Yes No
11. Tuberculosis.. Yes No
12. Family Member with Tuberculosis?.. Yes No
13. Latex Allergy?.. Yes No
14. Is patient under care of a physician at present?.. Yes No
15. Is patient now or has ever been under the care of a psychiatrist?.. Yes No

Is there any health condition not listed above?
Please describe ______________________

Are you taking any prescription or over-the-counter drugs?.. Yes No
Please list each one ______________________

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1. Do you breathe with your mouth open most of the time?.. Yes No
2. Have tonsils and adenoids been removed?.. Yes No
3. Do you suck your thumb?.. Yes No
4. Have you ever injured teeth in fall or accident?.. Yes No
   Was dental treatment required?.. Yes No
   Please comment and give approximate date of injury______________________

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5. Does any relative of the patient have a similar orthodontic problem?.. Yes No
   Relationship______________________

Continued on the Back

Who is responsible for the financial aspect of your orthodontic treatment?

Self_______ Other______________________

ORTHODONTIC INSURANCE INFORMATION

Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number

Insurance Company Address	
Insurance Phone Number	
Insured's Employer	

Do you have secondary **Orthodontic** coverage?		Yes Ọ No Ọ
Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number

Insurance Company Address	
Insurance Company Phone Number	
Insured's Employer	

Signature__________________________________ **Date**__________________

Thank you for choosing our office for your orthodontic care.