Date: ____/____/____

ADULT REGISTRATION FORM

PATIENT INFORMATION

❍ Mr. ❍ Ms. ❍ Dr. First M.I. Last
❍ Miss ❍ Mrs.

Home Address Street City State Zip

Telephone Home Mobile Office

❍ Male
❍ Female

Email Address Date of Birth/Age Social Security Number

Employer Business Address

Married? Spouse's Name
❍ Yes
❍ No

Employer Business Address

Business Phone Email Address

In case of emergency, contact: Telephone

Who may we thank for this referral?

Reason for consultation:

BILLING

Name of person assuming financial responsibility (if not yourself):

Billing Address Street City State Zip

E-mail Address Telephone

Do you have orthodontic insurance coverage? ❍ Yes ❍ No
If DUAL COVERAGE, make sure to complete both primary and secondary carrier sections.

INSURANCE

Primary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number Date of Birth

Secondary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number *Date of Birth*

YOUR HEALTHCARE PROVIDERS

MEDICAL HISTORY

Physician's Name	Telephone	Date of Last Visit	
Address	City	State	Zip

Yes	No	
❍	❍	Are you in good health?
❍	❍	Have you ever been under the care of a physician for an illness?
❍	❍	Do you have any history of major illness?
❍	❍	Have you ever been hospitalized?
❍	❍	Are you taking any drugs or medications? (List below under Additional comments)
❍	❍	Are you allergic to any medication? (List below)
❍	❍	Have you had any unusual reaction to a medication?
❍	❍	Have you taken any diet medications (i.e., Fen-Fen)?
❍	❍	Have you taken bisphosphonates (i.e., Fosamax, Actonel, Zometa)?
❍	❍	Do you take sedatives, tranquilizers, sleeping pills or medicine to relax?
❍	❍	Do you have trouble sleeping?
❍	❍	Do you snore when sleeping?
❍	❍	Have your tonsils and/or adenoids been removed? If yes, at what age?
❍	❍	If female: Are you pregnant?
❍	❍	Are you taking birth control pills?

Additional explanations or comments:

Check whether you have/had any of the following conditions:

- ❍ Heart Problems
- ❍ Hepatitis
- ❍ Kidney Problems
- ❍ Rheumatic Fever
- ❍ Lung Problems
- ❍ Nervous Problems
- ❍ Liver Problems
- ❍ Psychiatric Care
- ❍ Allergies
- ❍ Malignancies
- ❍ HIV+/AIDS
- ❍ Endocrine Problems
- ❍ Epilepsy
- ❍ Bone Disorders
- ❍ Arthritis
- ❍ Prolonged Bleeding
- ❍ Anemia
- ❍ Asthma
- ❍ Tuberculosis
- ❍ Implants
- ❍ Diabetes

Are you allergic or have reacted adversely to:

Yes	No	
❍	❍	Local anesthetics
❍	❍	Penicillin/other antibiotics
❍	❍	Sulfa drugs
❍	❍	Barbiturates, sedatives or sleeping pills
❍	❍	Aspirin
❍	❍	Codeine or other narcotics
❍	❍	Latex
❍		Other: ______________________

DENTAL HISTORY

Dentist's Name	Telephone	Date of Last Visit	
Address	City	State	Zip

Date of last dental exam: ______________________

Yes	No	
❍	❍	Have you previously consulted an orthodontist?
❍	❍	Have you ever had orthodontic treatment or been treated for a bad bite?
❍	❍	Is there clicking, popping or grating noise from your jaw when chewing?
❍	❍	Do you clench or grind your teeth?
❍	❍	Has there been any treatment for problems of your jaw joint or for facial muscle spasms?
❍	❍	Have there been any injuries to your face, mouth or teeth?
❍	❍	Have you had any previous unpleasant dental or orthodontic experiences? (Specify below)

Yes	No	
❍	❍	Is there numbness or tingling associated with your mouth or face?
❍	❍	Do your gums bleed on brushing or flossing? How many times/week do you floss? ________
❍	❍	Have you ever had periodontal (gum) disease?
❍	❍	Do you have any speech problems?
❍	❍	Have you been informed of any missing or extra teeth?
❍	❍	Are you a mouth breather?
❍	❍	Do you use a mouth guard or plastic splint?
❍	❍	Human Immunodeficiency Virus (HIV)

Additional explanations or comments:

Signature: ______________________________________ **Date:** ______________