braced ORTHODONTICS

ADULT REGISTRATION

PATIENT INFORMATION

Patient Name:	Sex: M / F	DOB:
SSN:	Age:	Email:

Mailing Address:	City:	State:	Zip Code:
Home #:	Cell #:	Name of Personal Responsible for Account:	

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Address:
Phone #:	Relationship to Patient:

DENTAL INSURANCE INFORMATION

Insurance Name:	Member ID #:	Group #:

Policy Holder's Information:

Name: DOB: SSN:

Name & Address of Policy Holder's Employer:

OTHER INFORMATION

How did you hear about our office?

DENTAL HISTORY

Please check any of the following that apply:

☐ Crowded Teeth Current Dentist: _____

- ☐ Narrow Jaws
- ☐ Underbite
- ☐ Overbite
- ☐ Jaw Joint Pain
- ☐ Grinding or Clenching Teeth
- ☐ Migraines
- ☐ Had orthodontics previously
- ☐ Has/had gum disease
- ☐ Has/had many cavities
- ☐ Wear on front teeth
- ☐ Wear on back teeth
- ☐ Missing teeth
- ☐ Has/had root canals
- ☐ Other: _____

City/State: _____
Phone #: _____
Last Cleaning: _____
Last Xrays: _____

If you could change your smile, would you:

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Close spaces
- ☐ Make smile wider
- ☐ Fix overbite/underbite
- ☐ Stop habit

What is most important to you about your future smile?

_____

What is most important to you about your visit today?

_____

MEDICAL HISTORY

Are you currently under a physician's care? ☐Yes ☐No For what? _____

Physician: _____ Phone#: _____

Please check any of the following that apply to you:

☐Acid Reflux	☐Depression	☐Respiratory Problems
☐ADHD/ADD	☐Diabetes	☐Restless Sleep
☐Anemia	☐Difficult Swallowing	☐Ringing/Buzzing of Ears
☐Anxiety	☐Epilepsy/Seizures	☐Scarlet Fever/Strep
☐Asthma	☐Headaches/Migraines	☐Sleep Apnea/Snoring
☐Back Problems	☐Heart Condition	☐Speech Problems
☐Behavior Problems	☐High Blood Pressure	☐Stomach Ulcer/ U.C.
☐Blood Disease	☐Kidney Disease	☐Tonsils/Adenoids Removed
☐Cancer	☐Liver Disease	☐Tubes in Ears

Are you allergic to any of the following?

☐Nickel ☐Other Metals
☐Antibiotic ☐Latex

Please list major surgeries you have had:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

What medications are you taking?

_____
_____
_____
_____

I certify that the information about my medical history is correct, to the best of my knowledge.

Patient Signature: _____ Date: _____