

ADULT'S REGISTRATION AND HEALTH HISTORY

Name: _____ Birth Date: _____ Sex: Male _____ Female _____
 Social Security # _____ Home Phone # _____ Cell # _____
 Email Address: _____
 Home Address: _____
 Employer: _____ Employer Address: _____
 Patient is: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____
 Name of Spouse: _____ Phone # _____
 Name and Address of Dentist: _____
 Date last Seen: _____ Reason: _____
 Name and Address of Physician: _____
 Date Last Seen: _____ Reason: _____
 Who may we thank for referring you to our office: _____
 Name and Address of Responsible Party: _____
 Insurance Coverage for Dental Treatment: Yes _____ No _____ Orthodontic Treatment: Yes _____ No _____
 Primary Policy's Holders Name: _____ Birth Date: _____ SS # _____
 Name and Address of Employer: _____
 Dental Insurance Company: _____ Group # _____
 Secondary Policy's Holders Name: _____ Birth Date: _____ SS # _____
 Name and Address of Employer: _____
 Dental Insurance Company: _____ Group # _____

DENTAL HISTORY

Now or in the past, have you had any of the following please answer all questions:

<input type="checkbox"/> Permanent or supernumerary (extra) teeth removed?	<input type="checkbox"/> Any pain or soreness in the muscles of the face or around the ears?
<input type="checkbox"/> Difficulty in chewing or jaw opening?	<input type="checkbox"/> Have you ever been treated for "TMD" or "TMJ"?
<input type="checkbox"/> Chipped or otherwise injured permanent teeth?	<input type="checkbox"/> Any teeth irritating cheek, lip, tongue or palate?
<input type="checkbox"/> Teeth sensitive to hot or cold; teeth throb or ache?	<input type="checkbox"/> Any relative with similar tooth or jaw relationships?
<input type="checkbox"/> Aware of loose, broken or missing restorations?	<input type="checkbox"/> Bleeding gums, bad taste or mouth odor?
<input type="checkbox"/> Jaw fractures, cysts or mouth infections?	<input type="checkbox"/> Periodontal "gum" problems or treatment?
<input type="checkbox"/> Any wisdom tooth problems?	<input type="checkbox"/> Had any serious trouble associated with previous dental treatment?
<input type="checkbox"/> Food impaction between teeth?	<input type="checkbox"/> Been under another dentist's care?
<input type="checkbox"/> Gum boils, frequent canker sores or cold sores?	Specialist _____
<input type="checkbox"/> Tooth grinding or jaw clenching?	Other _____
<input type="checkbox"/> History of speech problems?	<input type="checkbox"/> Ever had a prior orthodontic examination or treatment?
<input type="checkbox"/> Thumb, finger, or sucking habit? _____	<input type="checkbox"/> Aware or concerned about under or over developed jaw?
Until what age? _____	<input type="checkbox"/> Mouth breathing habit, snoring or difficulty in breathing?
<input type="checkbox"/> Abnormal swallowing habit (tongue thrusting)?	
<input type="checkbox"/> Any pain, clicking or locking in jaw or ringing in the ears?	
<input type="checkbox"/> Concerned about spaced, crooked or protruding teeth?	

How often do you brush? _____ Floss? _____
 What is your primary concern? _____

MEDICAL HISTORY

Now or in the past, have you had any of the following please answer all questions:

- | | |
|---|--|
| <input type="checkbox"/> Birth defects or hereditary problems? | <input type="checkbox"/> Excessive bleeding or bruising tendency anemia or bleeding disorder? |
| <input type="checkbox"/> Bone fractures, any major accidents? | <input type="checkbox"/> High or low blood pressure? |
| <input type="checkbox"/> Rheumatoid or arthritic conditions? | <input type="checkbox"/> Tire easily? |
| <input type="checkbox"/> Endocrine or thyroid problems? | <input type="checkbox"/> Chest pain, shortness of breath or swollen ankles? |
| <input type="checkbox"/> Kidney Problems? | <input type="checkbox"/> Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, heart defects, heart murmur or rheumatic heart disease)? |
| <input type="checkbox"/> Diabetes? | <input type="checkbox"/> Skin disorder? |
| <input type="checkbox"/> Cancer, tumor, radiation treatment or chemotherapy? | <input type="checkbox"/> Do you have a well balanced diet? |
| <input type="checkbox"/> Stomach ulcer or hyperacidity? | <input type="checkbox"/> Frequent headaches, colds or sore throats? |
| <input type="checkbox"/> Polio, mononucleosis, tuberculosis, pneumonia? | <input type="checkbox"/> Eye, ear, nose or throat conditions? |
| <input type="checkbox"/> Problems of the immune system? | <input type="checkbox"/> Hay fever, asthma, sinus trouble or hives? |
| <input type="checkbox"/> AIDS or HIV positive? | <input type="checkbox"/> Tonsil or adenoid conditions? |
| <input type="checkbox"/> Hepatitis, jaundice or liver problems? | <input type="checkbox"/> Osteoporosis? |
| <input type="checkbox"/> Fainting spells, seizures, epilepsy or neurological problem? | |
| <input type="checkbox"/> Mental health disturbance or depression? | |
| <input type="checkbox"/> Vision, hearing, tasting or speech difficulties? | |
| <input type="checkbox"/> Loss of weight recently, poor appetite? | |
| <input type="checkbox"/> History of eating disorder (anorexia, bulimia)? | |

Allergies or reactions to any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetics (Novocaine or Lidocaine) | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Ibuprofen (Motrin, Advil) | <input type="checkbox"/> Penicillin or other antibiotics |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Metals (jewelry, clothing snaps) | <input type="checkbox"/> Latex (gloves, balloons) |
| <input type="checkbox"/> Vinyl | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Foods _____ |
| <input type="checkbox"/> Other substances specify _____ | |

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Do you currently have or ever had a substance abuse problem? | Operations? _____ |
| <input type="checkbox"/> Do you chew or smoke tobacco? | Hospitalized? _____ |
| Other physical problems or symptoms? _____ | Date of most recent physical? _____ |
| Being treated by another health care professional? _____ | |
| Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? _____ | |

WOMEN ONLY

- | | |
|--|--|
| <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Are you anticipating becoming pregnant? |
|--|--|

FAMILY MEDICAL HISTORY

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain?

- | | |
|--|---|
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Severe allergies |
| <input type="checkbox"/> Unusual dental problems | <input type="checkbox"/> Jaw size imbalance |
| Any other family medical conditions that we should know about? _____ | |

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: _____ Date Signed: _____
(Patient)

Signed: _____ Date Signed: _____
(Dental Staff Member)