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:

_____Permanent or supernumerary (extra) teeth removed?
_____Difficulty in chewing or jaw opening?
_____Chipped or otherwise injured permanent teeth?
_____Teeth sensitive to hot or cold; teeth throb or ache?
_____Aware of loose, broken or missing restorations?
_____Jaw fractures, cysts or mouth infections?
_____Any wisdom tooth problems?
_____Food impaction between teeth?
_____Gum boils, frequent canker sores or cold sores?
_____Tooth grinding or jaw clenching?
_____History of speech problems?
_____Thumb, finger, or sucking habit? _____ Until what age?____
_____Abnormal swallowing habit (tongue thrusting)?
_____Any pain, clicking or locking in jaw or ringing in the ears?
_____Concerned about spaced, crooked or protruding teeth?
_____Any pain or soreness in the muscles of the face or around the ears?
_____Have you ever been treated for "TMD" or "TMJ"?
_____Any teeth irritating cheek, lip, tongue or palate?
_____Any relative with similar tooth or jaw relationships?
_____Bleeding gums, bad taste or mouth odor?
_____Periodontal "gum" problems or treatment?
_____Had any serious trouble associated with previous dental treatment?
_____Been under another dentist's care?
Specialist_____
Other_____
_____Ever had a prior orthodontic examination or treatment?
_____Aware or concerned about under or over developed jaw?
_____Mouth breathing habit, snoring or difficulty in breathing?

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:

_____Birth defects or hereditary problems?
_____Bone fractures, any major accidents?
_____Rheumatoid or arthritic conditions?
_____Endocrine or thyroid problems?
_____Kidney Problems?
_____Diabetes?
_____Cancer, tumor, radiation treatment or chemotherapy?
_____Stomach ulcer or hyperacidity?
_____Polio, mononucleosis, tuberculosis, pneumonia?
_____Problems of the immune system?
_____AIDS or HIV positive?
_____Hepatitis, jaundice or liver problems?
_____Fainting spells, seizures, epilepsy or neurological problem?
_____Mental health disturbance or depression?
_____Vision, hearing, tasting or speech difficulties?
_____Loss of weight recently, poor appetite?
_____History of eating disorder (anorexia, bulimia)?
_____Excessive bleeding or bruising tendency anemia or bleeding disorder?
_____High or low blood pressure?
_____Tire easily?
_____Chest pain, shortness of breath or swollen ankles?
_____Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, heart defects, heart murmur or rheumatic heart disease?
_____Skin disorder?
_____Do you have a well balanced diet?
_____Frequent headaches, colds or sore throats?
_____Eye, ear, nose or throat conditions?
_____Hay fever, asthma, sinus trouble or hives?
_____Tonsil or adenoid conditions?
_____Osteoporosis?

***Allergies or reactions to any of the following*:**

_____Local anesthetics (Novocaine or Lidocaine)
_____Ibuprofen (Motrin, Advil)
_____Sulfa drugs
_____Metals (jewelry, clothing snaps)
_____Vinyl
_____Animals
_____Other substances specify _____
_____Aspirin
_____Penicillin or other antibiotics
_____Codeine or other narcotics
_____Latex (gloves, balloons)
_____Acrylic
_____Foods_____

_____Do you currently have or ever had a substance abuse problem?
_____Do you chew or smoke tobacco?
Operations? _____
Hospitalized? _____
Date of most recent physical?_____
Other physical problems or symptoms? _____
Being treated by another health care professional? _____
Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? _____
_____

WOMEN ONLY

_____Are you pregnant?
_____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?

_____Bleeding disorders
_____Arthritis
_____Unusual dental problems
_____Diabetes
_____Severe allergies
_____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)