



Adult Patient Registration & Health History

Date: _____

*Patient's Name _____
Last Name First M.I. Nickname

*Patient's Birthdate _____ Age _____ Sex _____ Social Security # _____

*Marital Status _____ Spouse's Name _____

*Patient's Occupation _____ Employer _____ Work Phone # _____

*Patient's Address _____
Street City State Zip Code

Email Address _____ Home Phone # _____ Cell Phone # _____

Insurance

*Do you have Orthodontic/Dental Insurance? Yes No

*Orthodontic Insurance Provider _____ Subscriber's Name _____

*ID # _____ Group # _____ Subscriber's D.O.B. _____

Secondary Orthodontic Insurance Provider _____ Subscriber's Name _____

ID # _____ Group # _____ Subscriber's D.O.B. _____

Health Questionnaire

*Physician _____ City _____ Phone # _____

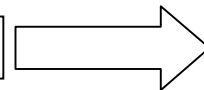
Do you have or have you had any of the following? Please check if it pertains to you.

- | | | |
|--|--|---|
| <input type="checkbox"/> Previous Hospitalization | <input type="checkbox"/> Medication Allergies | <input type="checkbox"/> X-rays {Medical/Dental} |
| <input type="checkbox"/> Previous Surgeries | <input type="checkbox"/> Allergies Other | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Recent Cold or flu | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nerve or muscle disease | <input type="checkbox"/> Chemo or Radiation Therapy |
| <input type="checkbox"/> Easy Bruising or Prolonged Bleeding | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Currently Pregnant |



Member American Association of Orthodontists

CONTINUED ON BACK



Health Questionnaire Continued

Do you have any other medical conditions not listed here? _____

List Medication Allergies (Including latex) _____

Are you currently under a physician's care? Yes No

Do you take medications? Yes No

If so, what kind? _____

Do you or have you taken bisphosphonate/osteoporosis medication? _____

Dental History

*Dentist _____ City _____ Phone # _____

Date of your last dental checkup _____

Are there any current dental problems under treatment or not being treated? _____

Was there previous orthodontic treatment? _____

What prompted you to seek orthodontic treatment? _____

Is there now or was there a history of: If yes, please explain and give dates if possible.

YES NO Thumb or finger habit _____

YES NO Pacifier or bottle habit _____

YES NO Fractured teeth _____

YES NO Root canal _____

YES NO Gum disease _____

YES NO Clicking or pain while opening _____

YES NO Injury to the face or jaws _____

YES NO Is the nasal airway clear? _____ Do you breathe through your nose _____ mouth _____ both? _____

YES NO Have you ever had a speech problem? _____ Speech therapy _____

YES NO Has any other family member received orthodontic treatment with our office. If so, whom? _____

YES NO Are there any problems, handicaps, or restrictions that may have a bearing on successful orthodontic treatment?

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

Patient Signature

I certify that the information above is complete and accurate.

LIVE LIFE SMILING