ARROWHEAD ORTHODONTICS

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.

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

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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

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