PATIENT REGISTRATION

Patient's Name _____

Employed by: _____
Street Address _____
City & State _____
Zip Code _____
Business Phone _____

Prefers to be called _____

Age_____ Birthdate_____ Sex____

Dentist _____
Date of Last Visit _____

Address:
Street or Route _____
City & State _____
Zip Code _____

Physician _____

Phone Number _____
Cell Phone _____
Phone # for reminder calls_____

Email _____

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

What is/are your concerns regarding your bite/teeth? _____

_____

Has any family member been treated by our office? _____ _____

Name of Family member treated _____ Relationship_____

Has the patient had any of the following: Circle Yes or No

1. Rheumatic Fever.....Yes No
2. Heart Condition.....Yes No
3. Diabetes.....Yes No
4. Epilepsy.....Yes No
5. Hemophilia (Bleeding Disorder).....Yes No
6. Allergies.....Allergic to what?_____.....Yes No
7. Drug Reaction ...Which drug?_____.....Yes No
8. Hepatitis.....Yes No
9. Venereal Disease.....Yes No
10. Aids or Related HIV.....Yes No
11. Tuberculosis.....Yes No
12. Family Member with Tuberculosis?.....Yes No
13. Latex Allergy?.....Yes No
14. Is patient under care of a physician at present?.....Yes No
15. Is patient now or has ever been under the care of a psychiatrist?.....Yes No

Is there any health condition not listed above?
Please describe _____

Are you taking any prescription or over-the-counter drugs?.....Yes No
Please list each one _____

_____

1. Do you breathe with your mouth open most of the time?.....Yes No
2. Have tonsils and adenoids been removed?.....Yes No
3. Do you suck your thumb?.....Yes No
4. Have you ever injured teeth in fall or accident?.....Yes No
   Was dental treatment required?.....Yes No
   Please comment and give approximate date of injury_____
   _____
5. Does any relative of the patient have a similar orthodontic problem?.....Yes No
   Relationship_____

Continued on the Back

Who is responsible for the financial aspect of your orthodontic treatment?

Self_____ Other_____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number
Insurance Company Address		
Insurance Phone Number		
Insured's Employer		

Do you have secondary **Orthodontic** coverage?		Yes O No O
Insured's Name		Insured's Social Security #
Insurance Company	Group Number	Local Number
Insurance Company Address		
Insurance Company Phone Number		
Insured's Employer		

Signature_____ **Date**_____

Thank you for choosing our office for your orthodontic care.