

Adult Registration and Health History Form

Name _____ Date _____

What name do you prefer that we call you? _____

Address _____ City & Zip _____ Years at above address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Whenever possible, we try to give a courtesy call before your appointments.

Which phone number would you like us to use? _____

Your email contact _____

Age _____ Sex _____ Birthdate _____ Social Security # _____

Occupation _____ Employer _____ Years with employer _____

Spouse's name _____ Work Telephone _____

Occupation _____ Employer _____ Years with employer _____

Marital Status: Single Married Widowed Separated Divorced

Person financially responsible for the account _____

If have orthodontic insurance, Insured's Social Security Number _____ Date of Birth _____

Whom do we contact in case of an emergency

(Other than spouse)? _____ Telephone _____

Has anyone in the family had orthodontic care? (Who?) _____

Have you had a previous orthodontic examination? (When & Where?) _____

Your dentist _____ **Date of last dental cleaning** _____

Your physician _____ Telephone _____

What are your interests / hobbies? _____

If you have any children, what are their names and ages? _____

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

Describe the orthodontic problem in your own words. _____

What concerns you most about the thought of orthodontic treatment?

appearance in appliances Cost Length of time Discomfort Results Other _____

Special requests / considerations or comments _____

PATIENT'S NAME _____ Height _____ Weight _____

An Explanation...

It is our desire to offer the finest treatment for you and/or your child. In order to plan the best treatment, it is important that we understand the medical/dental background of our patients. While some of the questions may seem personal, the answers may be very important to our planned orthodontic treatment. Thank you for your cooperation.

- Is the patient under the care of a physician? (who and why?) yes no
- Does the patient have a health problem now? (what?) yes no
- Is the patient presently taking **any** medications? (what?) yes no
- Is antibiotic necessary for dental procedures? (what?) yes no
- Is there a history of injury to face, head, or teeth? (what and when?) yes no
- Does the patient have any allergies? (what?) yes no
- Does the patient have problems or pain in the jaw joint (TMJ?) yes no
- Any pain, clicking or locking in jaw or ringing in the ears?..... yes no
- Any pain or soreness in the muscles of the face?..... yes no
- Does the patient have bleeding gums, gum problems, or history of periodontal (gum) treatment?..... yes no
- Is there a history of mouth breathing/snoring or difficulty breathing? (reasons?) yes no
- Is there a history of finger or thumb sucking? (until what age?) yes no
- Has the patient been hospitalized in the past three years?
(diagnosed condition?) yes no
- Does the patient have any mental or physical disability? (what?) yes no
- Do you chew or smoke tobacco?..... yes no Any history of a substance abuse problem?..... yes no

Women only: Are you pregnant?..... yes no Are you anticipating becoming pregnant?..... yes no

Has the patient ever had any of the following:

- | | | | | | |
|--------------------------------|--|------------------------------|--|-----------------------|--|
| AIDS or HIV positive | <input type="checkbox"/> yes <input type="checkbox"/> no | cytomegalovirus | <input type="checkbox"/> yes <input type="checkbox"/> no | measles/mumps | <input type="checkbox"/> yes <input type="checkbox"/> no |
| allergies(latex, metal, etc.) | <input type="checkbox"/> yes <input type="checkbox"/> no | diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no | mononucleosis/polio | <input type="checkbox"/> yes <input type="checkbox"/> no |
| anemia | <input type="checkbox"/> yes <input type="checkbox"/> no | epilepsy/seizures | <input type="checkbox"/> yes <input type="checkbox"/> no | organ transplant | <input type="checkbox"/> yes <input type="checkbox"/> no |
| arthritis/rheumatoid condition | <input type="checkbox"/> yes <input type="checkbox"/> no | heart murmur | <input type="checkbox"/> yes <input type="checkbox"/> no | osteoporosis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| asthma | <input type="checkbox"/> yes <input type="checkbox"/> no | cardiovascular/heart trouble | <input type="checkbox"/> yes <input type="checkbox"/> no | psychiatric treatment | <input type="checkbox"/> yes <input type="checkbox"/> no |
| bleeding disorder | <input type="checkbox"/> yes <input type="checkbox"/> no | hepatitis | <input type="checkbox"/> yes <input type="checkbox"/> no | shortness of breath | <input type="checkbox"/> yes <input type="checkbox"/> no |
| cancer treatment | <input type="checkbox"/> yes <input type="checkbox"/> no | herpes (any type) | <input type="checkbox"/> yes <input type="checkbox"/> no | sinus trouble | <input type="checkbox"/> yes <input type="checkbox"/> no |
| canker sores | <input type="checkbox"/> yes <input type="checkbox"/> no | high or low blood pressure | <input type="checkbox"/> yes <input type="checkbox"/> no | stroke | <input type="checkbox"/> yes <input type="checkbox"/> no |
| chicken pox | <input type="checkbox"/> yes <input type="checkbox"/> no | endocrine/thyroid problems | <input type="checkbox"/> yes <input type="checkbox"/> no | swelling of ankles | <input type="checkbox"/> yes <input type="checkbox"/> no |
| chronic cough | <input type="checkbox"/> yes <input type="checkbox"/> no | jaundice/liver problems | <input type="checkbox"/> yes <input type="checkbox"/> no | tuberculosis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| congenital heart lesion | <input type="checkbox"/> yes <input type="checkbox"/> no | kidney problems | <input type="checkbox"/> yes <input type="checkbox"/> no | venereal disease | <input type="checkbox"/> yes <input type="checkbox"/> no |

I hereby certify that I have read and understand the above questions and that the information provided is accurate to the best of my knowledge. I will not hold Dr. Gen 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 to this history later, I will so inform this practice. I also consent to the making of diagnostic records, including x-rays, before, during and following orthodontic treatment.

Patient's signature: _____ Date _____ Doctor's signature: _____ Date _____