ADULT HEALTH HISTORY AND REGISTRATION FORM

Today's Date: ____/_____/ 20_____

Patient Information

Last Name: _____ First:_____ Middle:_____ Title:_____

I prefer to be called:_____ Sex: ☐ Male ☐ Female

Date of Birth:____/____/_____ Social Security Number:_____

Home Address:_____

City: _____State: _____Zip Code:_____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Home #: (_____)_____ Wk #:(____)_____ Cell#:_____

Email:_____ (We confirm future appointments via email)

Who may we thank for referring you?_____

In case of an emergency, is there someone you would like us to contact? ☐ YES ☐NO

Name: _____Relation: _____ Phone Number: _____

Do you have orthodontic coverage with your insurance company? ☐ Yes ☐ No

Dental History

It is important that we know your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will NOT be released to anyone without your expressed written consent. Thank you for taking the time to completely fill out this questionnaire.

What are the main concerns that you would like orthodontics to accomplish? _____

_____

General Dentist:_____ Last visit date: _____

What is the date of your last Panorex or Full mouth x-ray? _____

	YES	NO
Do you brush and/or floss daily.....	☐	☐
Have there been any injuries to the face, mouth, teeth or chin?.....	☐	☐
Have you had any Periodontal (Gum) treatment?.....	☐	☐
Are there any jaw joint/ TMJ related issues?.....	☐	☐
Are you aware of grinding or clenching your teeth?.....	☐	☐
Have you worn braces or had previous orthodontic treatment?.....	☐	☐
Do you smoke or use tobacco in any form?.....	☐	☐
Have you ever taken Fen Phen (diet drug)?.....	☐	☐
For women: Are you or might you be Pregnant?.....	☐	☐
If so how many weeks?_____		
Are you planning on becoming pregnant?.....	☐	☐

Medical History

	YES	NO
Do you have any **current health problems**?	☐	☐
If yes, please list:_____		
Are you presently under a Physician's care?	☐	☐
If yes, what is the reason?_____		

Have you ever had any of the following medical problems?
Please circle:

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	ADD / ADHD	Y	N	Fever Blisters
Y	N	Allergies or Hives	Y	N	Heart Murmur/ Congenital heart lesion
Y	N	Anemia	Y	N	Hemophilia
Y	N	*Artificial Bones/ Hips/Joints	Y	N	Hepatitis A, B, or C
Y	N	Artificial Heart Valve	Y	N	HIV or AIDS
Y	N	Asthma	Y	N	Kidney or liver problems
Y	N	Cancer or Chemotherapy	Y	N	Rheumatic Fever
Y	N	Seizures	Y	N	Pain in Jaw /Joints

Please list all **medications** you are currently taking:_____

_____

Are you aware of being **allergic** to any medications, metals, latex or substances? (If yes please list)_____

_____

Please list any other medical or dental information that was not mentioned above: _____

_____

Is there any other information that may be pertinent to your treatment here? _____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature:_____ **Date**:____/_____/20____

_____

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I verbally reviewed the medical/ dental information above with the parent/ guardian and patient named herein.

Doctor's Comments: Initials:_____ Date: _____

_____

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