



PATIENT REGISTRATION & INFORMATION

Date: _____

Last Name _____ First _____ Middle _____ Sex _____

Birthdate _____ Age _____ Phone No. _____ Patient's Email _____
Home / Mobile / Work

Preferred method for automated appointment reminders (please circle ONE): EMAIL / TEXT MESSAGE / PHONE CALL

Address – Street _____

City _____ State _____ Zip Code _____

Name of Dentist / Dental Office _____

Address _____ Phone No. _____

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

Adult Patient: Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Occupation _____ Business Phone No. _____

Minor Patient: Birth Weight _____ Present Weight _____ Height _____

School _____ Grade Level _____

Favorite Sports and Hobbies _____

Musical Instruments Played _____

Number of Brothers and Sisters _____ Ages _____

Other Family Members Treated _____

Responsible Party Information, please list anyone who will be bringing the minor patient to appointments, responsible for financial matters, and responsible for treatment matters

Full Name _____ Sex _____ Relationship to Patient _____

Birthdate _____ Phone Number _____ Email _____

Full Name _____ Sex _____ Relationship to Patient _____

Birthdate _____ Phone Number _____ Email _____

Full Name _____ Sex _____ Relationship to Patient _____

Birthdate _____ Phone Number _____ Email _____

DENTAL (ORTHODONTIC) Insurance Coverage Yes _____ No _____

Insurance Co. Name _____ Policy/Group No. _____

Subscriber's Name _____ **DOB:** _____ Relationship to Patient _____

Subscriber's SSN # _____ **Subscriber's Insurance ID#** _____

*** The Social Security Number is **required** if a member/subscriber ID number is not known.*

Subscriber's Address (if different than patient's address) _____

City _____ State _____ Zip Code _____

*The following information is **required** if the insurance plan is provided by an employer*

Company Name _____ Group No. _____

Company Phone No. _____ Address _____

City _____ State _____ Zip Code _____

In Case We Cannot Reach You:

Name: _____ Phone No. _____ Relationship to Patient _____

Please continue on the back side...

For the following questions circle **yes**, **no**, or **don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Minors Only

| | |
|---|---|
| yes no dk/u Started teething very early or very late? | yes no dk/u Are you taking birth control pills? |
| yes no dk/u Does patient have trouble following directions? | yes no dk/u Is patient sensitive, self-conscious? |
| yes no dk/u Does patient have learning disabilities or need extra help with instructions? | |

Adults and Minors

| | |
|--|---|
| yes no dk/u Birth defects of hereditary problems? | yes no dk/u Bone fractures, any major accidents? |
| yes no dk/u Rheumatoid or arthritic conditions? | yes no dk/u Endocrine or thyroid problems? |
| yes no dk/u Kidney problems? | yes no dk/u Diabetes? |
| yes no dk/u Cancer or been treated for a tumor? | yes no dk/u Stomach ulcer or hyperacidity? |
| yes no dk/u Problems of the immune system? | yes no dk/u Loss of weight recently, poor appetite? |
| yes no dk/u Vision, hearing, tasting, or speech difficulties? | yes no dk/u High or low blood pressure? |
| yes no dk/u Fainting spells, seizures, epilepsy, or neurologic problem? | yes no dk/u Polio, mono, tuberculosis, pneumonia? |
| yes no dk/u Do you have a poor and unhealthy diet? | yes no dk/u Tires easily? |
| yes no dk/u Sexually transmitted diseases? Please list: _____ | yes no dk/u AIDS or HIV positive? |
| yes no dk/u Chest pain, shortness of breath, or swelling ankles? | yes no dk/u Eye, ear, nose, throat, tonsil, adenoid conditions? |
| yes no dk/u Hayfever, asthma, sinus trouble, hives? | yes no dk/u Hepatitis, jaundice or liver problem? |
| yes no dk/u Currently have or ever had a substance abuse problem? | yes no dk/u Are you pregnant or expecting to become pregnant? |
| yes no dk/u Are there any mental health problems? Please list: _____ | |
| yes no dk/u Excessive bleeding, black and blue tendency, anemia, or bleeding disorder? | |
| yes no dk/u Cardiovascular problem, heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, or rheumatic heart? | |
| yes no dk/u Allergies or drug reactions? Please list: _____ | |
| yes no dk/u Are you taking medication, supplements, or non-prescription medicine? Please list: _____ | |
| yes no dk/u Operations/Surgical procedures/Hospitalizations for: _____ | |
| yes no dk/u Other physical problems or symptoms? _____ | |
| yes no dk/u Is the patient seeing any other health care professional? For _____ | |

Dental History

Minors Only

| | |
|---|--|
| yes no dk/u Does patient have trouble following directions? | yes no dk/u Removal of (baby) teeth that were not loose? Onset of puberty (approximate age) _____ |
|---|--|

Adults and Minors

| | |
|--|--|
| yes no dk/u Prior orthodontic treatment? When? _____ | yes no dk/u Jaw fractures, cysts, mouth infections? |
| yes no dk/u Permanent or "extra" (supernumerary) teeth removed? | yes no dk/u Bleeding gums, bad taste, mouth odor? |
| yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache? | yes no dk/u Periodontal disease, "Gum Problems"? |
| yes no dk/u "Dead Teeth", root canals treated? | yes no dk/u Food impaction between teeth? |
| yes no dk/u Thumb, finger, sucking habit? Until _____ | yes no dk/u History of speech problems? |
| yes no dk/u Abnormal swallowing habit (tongue thrusting)? | yes no dk/u Difficulty chewing or opening jaw? |
| yes no dk/u Mouth breathing habit, snoring, difficulty in breathing? | yes no dk/u Any pain in jaw or ringing in the ears? |
| yes no dk/u Tooth grinding, jaw clenching, clicking, locking? | yes no dk/u Any relative with similar tooth or jaw problems? |
| yes no dk/u Aware or concerned about under or over developed jaw? | yes no dk/u Loose, broken, or missing restorations (fillings)? |
| yes no dk/u Concerned about spaced, crooked, protruding teeth? | yes no dk/u Any wisdom tooth problems? |
| yes no dk/u Has patient ever had periodontal (gum) treatment? | |
| yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain)? | |
| yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears? | |
| yes no dk/u Has patient had any serious trouble associated with any previous dental treatment? | |
| yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated? | |

Date of last dental visit _____ Were x-rays taken? Yes / No / DK/U Date of last cleaning _____ How often does patient brush? _____ Floss? _____

What is the patient's (or guardian's) primary concern? Why are you here today? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

| | | |
|--|---------------------------|-------------------|
| Signature of patient/guardian _____ | Printed Name _____ | Date _____ |
|--|---------------------------|-------------------|

| | |
|------------------------|------|
| Dr. Matthew A. Sanders | Date |
|------------------------|------|

MEDICAL & DENTAL HISTORY UPDATE – Should be completed at least once a year. Are there any changes to your medical and dental history that we should be aware of? Please write "none" or explain: _____

| | | |
|--|---------------------------|-------------------|
| Signature of patient/guardian _____ | Printed Name _____ | Date _____ |
|--|---------------------------|-------------------|

| | |
|------------------------|------|
| Dr. Matthew A. Sanders | Date |
|------------------------|------|