Orthodontic Patient Registration and Health History Form

Patient First Name: _____ Middle Name: _____ Last Name: _____
Patient/Responsible Party Street Address: _____
City: _____ State: _____ Zip: _____
Cell phone: ( ) _____ Home phone: ( ) _____
Nickname: _____ Sex: M F Age: _____ Birthdate: _____ / _____ /_____
Sports or Hobbies: _____
E-mail Address: _____

Other Family Members Treated here? _____
Primary Responsible Party (Parent or Legal Guardian if under 18):_____
Employer: _____ Position: _____ Work phone: ( ) _____
Responsible Party #2:_____
Employer: _____ Position: _____ Work phone: ( ) _____

Main Concern/Chief Complaint: _____

Any prior orthodontic treatment? Y N If so, where/when? _____
What is most important to you in selecting an orthodontic office? _____
Are you considering metal braces, clear braces or Invisalign? _____
Is treatment time a primary concern? Yes____ No____

REFERRAL SOURCE:
Who may we thank for referring you: _____
How do you know them? ☐ Friends & Family ☐Our patients/staff ☐ Dentist ☐ Physician ☐Other _____
Have you heard about our practice in other ways? Check all that apply: ☐ TV/Radio ☐ Google Search/Online
☐ Our patients/staff ☐ Social Media ☐ Direct Mail ☐ Insurance Plan ☐ Employer ☐ Office Sign ☐Invisalign Website ☐ Event Sponsorship ☐ Yellow Pages ☐ Other _____
How would you like your appointment(s) confirmed? Email _____ Phone Call _____ Text _____

INSURANCE:
Primary Ins. Holder Name: _____ DOB: _____ /_____ /_____
Primary Ins. Holder Employer: _____Primary Ins. Company: _____
Primary ID/SSN #:_____Primary Group #:_____ Phone# of Ins. company: ( ) _____
Secondary Ins. Holder Employer: _____Primary Ins. Company: _____
Secondary Ins. Holder Employer: _____ Secondary Ins. Company:_____
Secondary ID/SSN #:_____Group #:_____ Secondary Phone#: ( ) _____

INFORMATION AND PAYMENT AUTHORIZATION RELEASE:
I authorize the release of any information relating to this claim and understand that I am responsible for all costs of dental treatment and authorize payment directly to _____ of the group insurance benefits otherwise payable to me.

_____ _____
Signature (Responsible Party) Date

DENTAL HISTORY:

Dentist Name: _____ Periodontist Name:_____
Oral Surgeon Name: _____ Endodontist Name:_____
How many times a day do you brush your teeth? _____ Do you Floss? _____
Date of last cleaning/prophy? _____ Last Panoramic X-Ray Date? _____

Have you ever had:

Orthodontic treatment	Yes____ No____	Clicking of the jaw	Yes____ No____
Oral Surgery	Yes____ No____	Pain (joint, ear, face)	Yes____ No____
Wisdom Teeth Extracted	Yes____ No____	Periodontal treatment	Yes____ No____
Your bite adjusted	Yes____ No____	Difficulty opening or closing	Yes____ No____
Difficulty chewing	Yes____ No____	Worn a bite plate (retainer)	Yes____ No____
Missing or extra teeth	Yes____ No____		

Habits:

Bite your fingernails	Yes____ No____	Bite your lip/cheeks regularly	Yes____ No____
Clench or grind your teeth	Yes____ No____	Mouth breathe	Yes____ No____
Thumb or tongue habit	Yes____ No____		

Do you have headaches? Yes____ No____ Frequency _____ Location_____
Have you ever had trauma or injury to the teeth or face? _____

MEDICAL HISTORY:

Physician Name: _____

AIDS, HIV +	Yes____ No____	Head/Neck pain	Yes____ No____
Anemia	Yes____ No____	Heart Disease	Yes____ No____
Arthritis	Yes____ No____	Kidney Disease	Yes____ No____
Asthma	Yes____ No____	Liver/Hepatitis	Yes____ No____
Cancer	Yes____ No____	Prolonged Bleeding	Yes____ No____
Diabetes	Yes____ No____	Respiratory Disease	Yes____ No____
Dizziness	Yes____ No____	Rheumatic Fever	Yes____ No____
Fainting	Yes____ No____	Tuberculosis	Yes____ No____
Epilepsy	Yes____ No____	Are you pregnant	Yes____ No____

List all drugs or medications now being taken: _____
List Allergies: _____
Have you ever been treated for a bone disorder or osteoporosis? Yes____ No____
Have you/or are you taking any Bisphosphonates medications (i.e. Fosamax & Boniva)? Yes____ No____
Have you had any major operations? Y N (please describe):_____
Any other medical considerations: _____

Airway/Sleep Evaluation:

Have the tonsils/adenoids been removed?	Yes____ No____
Do you snore or have you been told that you snore?	Yes____ No____
Do you have excessive daytime sleepiness?	Yes____ No____
Do you wake up during the night?	Yes____ No____
Have you ever had a sleep study?	Yes____ No____
Do you have high blood pressure?	Yes____ No____

I, the undersigned, have given the above dental and medical information, have reviewed it and find it accurate. If there are any changes in my history, I will inform the practice.

_____ _____
Signature Date