ORTHODONTIC REGISTRATION FORM

Thank you for taking the time to complete this form before your first visit. We look forward to meeting you!

ADULT PATIENT INFORMATION

TITLE ☐ DR. ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ REV.

NAME _____ *first* _____ *m.i.* _____ *last* _____ *preferred name* _____

BIRTHDATE _____ AGE _____ ☐ MALE ☐ FEMALE

MAILING ADDRESS _____ *Street* _____ *city* _____ *state* _____ *zip* _____

PHONE (HOME) (____) _____ (MOBILE) (____) _____ (WORK) (____) _____

EMPLOYER _____ OCCUPATION _____ #YRS _____

EMAIL _____ APPOINTMENT REMINDERS? ☐ YES ☐ NO

HAS ANY OTHER MEMBER OF YOUR FAMILY BEEN TREATED IN OUR OFFICE? IF YES, WHO? _____

DENTAL/ORTHODONTIC INSURANCE (COMPANY) _____ SSN _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

HOBBIES AND SPORTS _____ MUSICAL INSTRUMENT ♬ _____

DENTIST _____ DATE OF LAST VISIT _____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE ☐ DENTIST _____

☐ FRIEND _____

☐ OTHER _____

WHAT WOULD YOU LIKE ORTHODONTIC TREATMENT TO ACCOMPLISH? _____

HAS ANOTHER ORTHODONTIST BEEN CONSULTED OR PREVIOUS ORTHODONTIC TREATMENT BEEN PROVIDED? ☐ YES ☐ NO

IF YES, WHAT WORK HAS BEEN COMPLETED AND BY WHOM? _____

SPOUSE INFORMATION

TITLE ☐ DR. ☐ MR. ☐ MRS. ☐ REV.

NAME _____ *first* _____ *m.i.* _____ *last* _____ *preferred name* _____

BIRTHDATE _____ AGE _____ ☐ MALE ☐ FEMALE

PHONE (HOME) (____) _____ (MOBILE) (____) _____ (WORK) (____) _____

EMPLOYER _____ OCCUPATION _____ #YRS _____

DENTAL/ORTHODONTIC INSURANCE (COMPANY) _____ SSN _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD

EMERGENCY CONTACT INFORMATION

NAME _____ *first* _____ *m.i.* _____ *last* _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ *Street* _____ *city* _____ *state* _____ *zip* _____

PHONE (HOME) (____) _____ (MOBILE) (____) _____ (WORK) (____) _____

Nicholas R. Smith, DDS, MS, PC
Diplomate, American Board of Orthodontics

DENTAL HISTORY

Check if you have or have had any of the following:

☐ Bleeding Gums	☐ Grinding Teeth	☐ Jaw Lock Open/Closed	☐ Pain around Ear
☐ Blisters on Lips/Mouth	☐ Gums Sore/Swollen	☐ Jaw Pain/Tenderness	☐ Periodontal Treatment
☐ Dry Mouth	☐ Injuries to Teeth/Jaws	☐ Lip/Cheek Biting	☐ Periodontal Surgery
☐ Extracted Teeth	☐ Injuries to Face/Head	☐ Loose Teeth	☐ Speech Problems
☐ Finger/Thumb Habits	☐ Jaw Clicking/Popping	☐ Mouth Breathing	☐ Tongue Thrust

How often do you brush? _____ How often do you floss? _____

Hand used to brush teeth: ☐ Right ☐ Left How would you rate your overall dental health? Poor < 0 1 2 3 4 5 > Great

Please list any family history of orthodontic/Jaw problems: _____

Additional Comments:

MEDICAL HISTORY

Check if you have or have had any of the following:

☐ AIDS/HIV+	☐ Circulatory Problems	☐ Heart Murmur	☐ Respiratory Disease
☐ Anemia	☐ Cortisone Treatment	☐ Heart Problems	☐ Rheumatic Fever
☐ Arthritis	☐ Coughing – Persistent	☐ Hemophilia	☐ Stroke
☐ Artificial Heart Valves	☐ Cough Up Blood	☐ Hepatitis	☐ Stomach Ulcer
☐ Artificial Joints	☐ Diabetes	☐ High Blood Pressure	☐ Thyroid Problems
☐ Asthma	☐ Endocrine Problems	☐ Kidney Disease	☐ Tobacco Use
☐ Bleeding Disorder	☐ Epilepsy	☐ Liver Disease	☐ Tonsillitis
☐ Bone Disorders	☐ Fainting	☐ Pacemaker	☐ Tonsils Removed
☐ Cancer	☐ Glaucoma	☐ Psychiatric Care	☐ Tuberculosis (TB)
☐ Chemotherapy	☐ Headaches	☐ Radiation Treatment	☐ Shortness of Breath

Are you under the care of a physician? ☐ Yes ☐ No If yes, please describe _____

Do you smoke or chew tobacco? ☐ Yes ☐ No Females: Is it possible you are pregnant? ☐ Yes ☐ No

Have you ever been required to take antibiotics (Pre-Medication) prior to a dental visit? ☐ Yes ☐ No

Do you have an allergy or sensitivity to Latex, Metals or Plastics? ☐ Yes ☐ No

Have you ever taken a **bisphosphonate medication**, such as: Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa? ☐ YES ☐ NO

How would you rate your overall physical health? Poor < 0 1 2 3 4 5 > Great

Additional Comments:

MEDICATIONS

Please list **ANY & ALL** medications you are currently taking:

_____

_____

ALLERGIES

Please list **ANY & ALL** allergies you are aware of:

_____

_____

I understand the information provided today is correct to the best of my knowledge. This information will be held in the strictest confidence, and I understand it is my responsibility to inform this office of any changes in my medical status. I understand that it is the office's policy to scan and store original documents in electronic form. I acknowledge that any agreement bearing a scanned signature, which is printed from the electronic form, has the same force and effect as the original document.

Patient Signature: _____ *Date:* _____

I authorize the release of any information necessary to process my insurance claim and to communicate with other doctors who may be involved in my health care. I understand that prior to extending credit for treatment fees, a credit bureau report may be obtained.

Patient Signature: _____ *Date:* _____

Nicholas R. Smith, DDS, MS, PC
Diplomate, American Board of Orthodontics