ADULT REGISTRATION AND HEALTH HISTORY FORM

Name ______________________________ Date ____________

What name do you prefer 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 this 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 ☐ Discomfort ☐ Quality of treatment ☐ Low Down Payment

☐ Cost ☐ Results ☐ Latest Technology ☐ Low Monthly Payment

☐ Length of Treatment ☐ Comfort ☐ Clear Technology

I understand that appropriate credit bureau reports may be obtained.
Medical inquiries do not affect your credit score.

Signature (Patient's signature, if minor) ______________________________ Date ________

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

Are antibiotics 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:

Condition			Condition			Condition		
AIDS or HIV positive	☐ yes	☐ no	Cytomegalovirus	☐ yes	☐ no	Measles/Mumps	☐ yes	☐ no
Allergies (latex, metal, etc.)	☐ yes	☐ no	Diabetes	☐ yes	☐ no	Mononucleosis/polio	☐ yes	☐ no
Anemia	☐ yes	☐ no	Epilepsy/Seizures	☐ yes	☐ no	Organ transplant	☐ yes	☐ no
Arthritis/Rheumatoid Condition	☐ yes	☐ no	Heart Murmur	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Asthma	☐ yes	☐ no	Cardiovascular/Heart Trouble	☐ yes	☐ no	Psychiatric Treatment	☐ yes	☐ no
Bleeding Disorder	☐ yes	☐ no	Hepatitis	☐ yes	☐ no	Shortness of Breath	☐ yes	☐ no
Cancer Treatment	☐ yes	☐ no	Herpes (any type)	☐ yes	☐ no	Sinus Trouble	☐ yes	☐ no
Canker Sores	☐ yes	☐ no	High or Low Blood Pressure	☐ yes	☐ no	Stroke	☐ yes	☐ no
Chicken Pox	☐ yes	☐ no	Endocrine/Thyroid Problems	☐ yes	☐ no	Swelling of Ankles	☐ yes	☐ no
Chronic Cough	☐ yes	☐ no	Jaundice/Liver Problems	☐ yes	☐ no	Tuberculosis	☐ yes	☐ no
Congenital Heart Lesion	☐ yes	☐ no	Kidney Problems	☐ yes	☐ no	Venereal Disease	☐ yes	☐ 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 ____________________ Doctor's signature ____________________ Date __________

CHILD REGISTRATION AND HEALTH HISTORY FORM

Patient's name_______________________ Social Security# ____________

Nickname____________ Age____________ Sex ______ Birthdate ____________

Address ____________________ City/Zip ______________ Years at above address _____

Father's name ______________________ Occupation ____________________

Employer ______________ Years with employer _______ Business phone ____________

Mother's name ______________________ Occupation ____________________

Employer ______________ Years with employer _______ Business phone ____________

Home Phone ______________ Cell Phone __________________ (☐ Mother ☐ Father)

Whenever possible, we try to give a courtesy (confirmation) call before your appointments. Which number would you like us to use? Preferred email contact __________________ (☐ Mother ☐ Father)

Parent's Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Person financially responsible for this account ______________________________

If there is orthodontic insurance, Insured's Social Security Number ____________ Date of Birth ________

Whom do we contact in case of an emergency? (Other than parent?)

Name ______________________________ Telephone ____________________

Father's/Mother's address if different from patient ______________________________

Brother's/Sister's names and birthdates ______________________________

Has anyone in the family had orthodontic care? (who?) ______________________________

Is the patient adopted? ____________________ If "Yes", does the patient know? ____________

Patient's physician ______________________ Telephone ____________________

Patient's dentist ______________________ Date of last dental cleaning ____________

What are the patient's hobbies and sports? ______________________________

Patient's school ____________________ Grade ______ Musical Instruments played ____________

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

Do you have any friends or relatives who come to our office? ______________________________

Who noticed the orthodontic problem? ☐ Patient ☐ Parent ☐ Dentist ☐ Other ____________

Describe the orthodontic concern in your own words. ______________________________

What concerns you most about the thought of orthodontic treatment?

☐ Appearance in appliances ☐ Discomfort ☐ Quality of treatment ☐ Low Down Payment

☐ Cost ☐ Results ☐ Latest Technology ☐ Low Monthly Payment

☐ Length of Treatment ☐ Comfort ☐ Clear Technology

I understand that appropriate credit bureau reports may be obtained.
Medical inquiries do not affect your credit score.

Signature (Patient's signature, if minor) ______________________________ Date __________

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

Are antibiotics necessary for dental procedures? (what?) .... ☐ yes ☐ no

Does patient have learning disabilities or needs extra help with instructions? .... ☐ yes ☐ no

Does the patient have any allergies? (what?) .... ☐ yes ☐ no

Have the tonsils and/or adenoids been removed? (what and when?) .... ☐ yes ☐ no

Is there a history of ear infection, sore throats, or frequent colds? (which and how frequent?) .... ☐ 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

Is there a history of injury to face, head, or teeth? (what and when?) .... ☐ yes ☐ no

Does the patient have problems or pain in the jaw joint? (TMJ?) .... ☐ yes ☐ no

Tooth grinding, jaw clenching, or any clicking, locking in jaw? .... ☐ 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

What are the chief concerns you have related to the position of your child's teeth or bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability ☐ Other: __________

Does the patient chew or smoke tobacco? ☐ yes ☐ no Any history of a substance abuse problem? ☐ yes ☐ no

<u>Girls only:</u> Started her monthly period? (when?) ☐ yes ☐ no Is the patient pregnant? ☐ yes ☐ no

<u>Boys:</u> Has his voice changed? (when?) ☐ yes ☐ no

<u>Has the patient ever had any of the following:</u>

Condition		Condition		Condition	
AIDS or HIV positive	☐ yes ☐ no	Cytomegalovirus	☐ yes ☐ no	Measles/Mumps	☐ yes ☐ no
Allergies (latex, metal, etc.)	☐ yes ☐ no	Diabetes	☐ yes ☐ no	Mononucleosis/polio	☐ yes ☐ no
Anemia	☐ yes ☐ no	Epilepsy/Seizures	☐ yes ☐ no	Organ transplant	☐ yes ☐ no
Arthritis/Rheumatoid Condition	☐ yes ☐ no	Heart Murmur	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no
Asthma	☐ yes ☐ no	Cardiovascular/Heart Trouble	☐ yes ☐ no	Psychiatric Treatment	☐ yes ☐ no
Bleeding Disorder	☐ yes ☐ no	Hepatitis	☐ yes ☐ no	Shortness of Breath	☐ yes ☐ no
Cancer Treatment	☐ yes ☐ no	Herpes (any type)	☐ yes ☐ no	Sinus Trouble	☐ yes ☐ no
Canker Sores	☐ yes ☐ no	High or Low Blood Pressure	☐ yes ☐ no	Stroke	☐ yes ☐ no
Chicken Pox	☐ yes ☐ no	Endocrine/Thyroid Problems	☐ yes ☐ no	Swelling of Ankles	☐ yes ☐ no
Chronic Cough	☐ yes ☐ no	Jaundice/Liver Problems	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no
Congenital Heart Lesion	☐ yes ☐ no	Kidney Problems	☐ yes ☐ no	Venereal Disease	☐ yes ☐ no

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Parent's signature ____________________ Doctor's signature ____________________ Date ________