ADULT REGISTRATION AND HEALTH HISTORY FORM

Success Orthodontics®

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?)

Name_____ 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

<u>Women only:</u> Are you pregnant? ☐ yes ☐ no

Are you anticipating becoming pregnant? ☐ yes ☐ no

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

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 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 _____