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
Women only: Are you pregnant?	yes	no	Are you anticipating becoming pregnant?	yes	no

Has the patient ever had any of the following:

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 _____