Orthodontic Registration
Adult Form

PATIENT'S INFORMATION

Today's date: _______________M__F__
Name _____________________________
Preferred Name: ____________________
SS#: ______________________________
Birth Date: ________________Age: ___
Home#: __________Cell#: ___________
E-mail Address: _____________________
Home Address:______________________
____
How long at this address? _____________
Marital Status: Single ____ Married _____
Separated ___Widowed ___Divorced ____

EMPLOYER INFORMATION

Employer: ___________________________
Address: ____________________________
____
Work#: _____________________________
How long employed here? _____________
Position: ____________________________

RESPONSIBLE PARTY

Name: _____________________________
Relationship to Patient: _______________
Billing Address: _____________________
____
Previous Address: ___________________
____
Home#: __________Work#: ___________
Cell#: ______________________________
E-mail Address: _____________________
Employer: ___________________________
Employer Address: __________________
____
SS#: _______________________________

PRIMARY ORTHODONTIC INSURANCE COVERAGE

Orthodontic Coverage: Yes ___ No ___
Insurance Co. Name: _______________
Insurance Co. Address: ______________
____
Insurance Co. Phone #: ______________
Group# (Plan, Local, or Policy#): _____
____
Policy Owner's Name: ______________
Relationship to Patient: ______________
Policy Owner's Birth Date: ___________
SS#: ______________________________
Policy Owner's Employer: ___________
____

SECONDARY ORTHODONTIC INSURANCE COVERAGE

Orthodontic Coverage: Yes ___ No ___
Insurance Co. Name: _______________
Insurance Co. Address: ______________
____
Insurance Co. Phone #: ______________
Group# (Plan, Local, or Policy#): _____
____
Policy Owner's Name: ______________
Relationship to Patient: ______________
Policy Owner's Birth Date: ___________
SS#: ______________________________
Policy Owner's Employer: ___________
____

MEDICAL HISTORY

Y N Abnormal Bleeding
Y N Allergies to any Medications
Y N Allergic to Latex or Metals
Y N Allergic to Plastics
Y N Any Hospital Stays
Y N Asthma
Y N Cancer
Y N Congenital Heart Defects
Y N Convulsions/Epilepsy
Y N Diabetes

MEDICAL HISTORY (CON'T)

Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Rheumatic Fever/Scarlet Fever
Y N Seasonal Allergies
Y N Tuberculosis

Please describe any medical problems you have/had: ___________________________
____
____

WHY DID YOU SEEK THIS CONSULTATION? _________________
____

ORTHODONTIC CONSULTATION PROMPTED BY? __________________
____

Who is your general dentist?
____

Date of last dental cleaning ___________

Have you ever been told you have periodontal (gum) disease? Y N

Have you ever been evaluated or had orthodontic treatment before? Y N

Have there been any injuries to the face, mouth, teeth, or chin? Y N

List any musical instruments played:
____

Have adenoids and/or tonsils been removed? Y N

Have you ever been informed of any missing or extra teeth? Y N

Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)? Y N

Do you brush your teeth at least twice a day? Y N

Do you floss your teeth at least once a day? Y N

Physician: _________________________

Phone#: ____________________________

Date of Last Visit: __________________

Are you currently under the care of a physician? Y N

Please describe your physical health:
Good _______ Fair _______ Poor ______

Please list all drugs you are taking:
____

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Snoring
Y N Speech Problems
Y N Tongue Thrust

EMERGENCY INFORMATION

Name of nearest relative not living with you: ____________________________

Relationship to Patient: _____________

Complete Address: ________________
____

Phone Number: __________________

I HEREBY CERTIFY THAT I HAVE REVIEWED THE ABOVE MEDICAL / DENTAL HISTORY AND THAT IT IS ACCURATE TO MY KNOWLEDGE AT THIS TIME. IF THERE ARE ANY FUTURE CHANGES IN THE INFORMATION I WILL INFORM DR. BENEDICT IMMEDIATELY.

____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________, have received a copy of this office's Notice of Privacy Practices.

____
Signature Date

____

____FOR OFFICE USE ONLY___

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Signature of witness __________
  Date ___________