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ADULT PATIENT REGISTRATION

Date ____________

Patient ______________________ Sex ____ Birthdate ________ Age ____
First M.I. Last

Address ______________________ City __________ State ____ Zip Code ______

Social Security Number ______________________ Cell Phone (____) ____________

Employer ______________________ Secondary Phone (____) ____________

Employer Address ______________________ Email Address ____________

Dental Insurance: No___ Yes ___ Primary______________ Secondary ____________

Responsible party if different from above:

______________________ Sex ____ Birthdate ________ Age ____
First M.I. Last

Address ______________________ City __________ State ____ Zip Code ______

Social Security Number ______________________ Cell Phone (____) ____________

Employer ______________________ Secondary Phone (____) ____________

Employer Address ______________________ Email Address ____________

Relationship to Patient: ______________________

Dental Insurance: No___ Yes ___ Primary______________ Secondary ____________

Patient's Dentist ______________________ City ____________

Date of last dental exam ______________________ Date of last dental X-rays ____________

Whom may we thank for referring you? ______________________

Why did you select our office? ______________________

Names of other family members previously seen at our office: ______________________

Son / Daughter name______________ age______ had orthodontic treatment? ☐ Yes ☐ No
If yes, where? ______________________

Son / Daughter name______________ age______ had orthodontic treatment? ☐ Yes ☐ No
If yes, where? ______________________

Son / Daughter name______________ age______ had orthodontic treatment? ☐ Yes ☐ No
If yes, where? ______________________

(PLEASE COMPLETE BOTH SIDES)

SP-016

Patient Medical History

Patient's Physician ______________________ Clinic ______________________

Currently under a physician's care? ________ Reason ______________________

Have you been hospitalized in the last 5 years? ________ Reason ______________________

List all medications, nutritional supplements, herbal medicines, and/or non-prescription medications you are currently taking: ______________________

____

Do you chew or smoke tobacco? _______ If no, have you ever? _______ If so, when did you quit? ________

Do your parents or siblings have any unusual dental problems or jaw size imbalance? ________

What concerns you about your teeth/smile? ______________________

List all allergies including metal allergies: ______________________

____

Has the patient ever had:	***YES***	***NO***		***YES***	***NO***
Abnormal Blood Pressure *(High _____ Low _____)*	_____	_____	Heart Problems: *(circle all that apply) (heart attack, angina, coronary insufficient, arteriorsclerosis, stroke, inborn heart defects, heart murmur, or rheumatic heart disease)? Do you take Nitroglycerin?* _______	_____	_____
AIDS or HIV Positive	_____	_____			
Birth Defects or Hereditary Problems?	_____	_____			
Bone Fractures and/or Major Accidents	_____	_____			
Cancer, Tumor, Radiation or Chemotherapy?	_____	_____	Hepatitis *(Circle A, B, C)*	_____	_____
Chemical Dependency *(Drugs, Alcohol)*	_____	_____	Joint Replacement or Implant	_____	_____
Diabetes: Diet Controlled	_____	_____	Mental Health Disturbance or Depression?	_____	_____
Insulin Controlled	_____	_____	Polio, Mononucleosis, Tuberculosis, or Pneumonia?	_____	_____
Eating Disorder History (anorexia, bulimia)?	_____	_____			
Endocrine or Thyroid Problems?	_____	_____	Rheumatic Fever	_____	_____
Epilepsy	_____	_____	Stomach Ulcers or Hyperacidity?	_____	_____
Excessive Bleeding or Bruising Tendency, Anemia, or other Bleeding Problem?	_____	_____	Asthma	_____	_____
			Women: Are you pregnant?	_____	_____
Glaucoma	_____	_____	Are antibiotics required for dental work?	_____	_____

Have you ever taken **Fosamax, Zometa, Boniva, Actonel, Aredia** or any other medications for osteoporosis or bone cancer?

____

List other diseases, conditions or problems not listed above: ______________________

____

Describe any serious injury to your face, jaw or mouth: ______________________

____

Describe any problems with your jaw:

Clicking? ______________________

Pain (Joint, ear, side of face)? ______________________

Frequent headaches? ______________________

Difficulty in opening or closing? ______________________

Jaw ever locked or popped? ______________________

Clench or grind your teeth? ______________________

Have you ever had T.M.J. therapy? ______________________

I hereby authorize the release of any information relating to dental claims for benefits submitted on my behalf of myself, and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes Cambridge Pine City Orthodontics to submit claims to my insurance carrier for dental benefits, for services rendered or to be rendered, without obtaining my signature on each individual claim to be submitted for myself and/ or dependents.

I hereby authorize payment of dental benefits, otherwise payable to me, directly to Cambridge Pine City Orthodontics.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my childs medical or dental health.

Signature:______________________ **Date:**____/____/____