

Safer Orthodontics, LLC
NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Patient's Full Name _____ M ☐ F ☐ Age _____ Date of Birth ____/____/____
Preferred Name _____ Home Phone _____ Cell Phone _____
Best Method to Reach You _____ E-mail _____
Home Address _____ City _____ State _____ Zip Code _____
Whom May We Thank for Referring you to our Practice? _____
Would you like to receive appointment reminders via text message? Y ☐ N ☐ Cell Phone Carrier _____
Would you like to receive appointment reminders via e-mail? Y ☐ N ☐

PATIENT'S UNDER 18:

Father's Name _____ Cell Phone _____
Mother's Name _____ Cell Phone _____
School currently attending _____ Grade _____

RESPONSIBLE PARTY INFORMATION:

First Name _____ Last Name _____ Date of Birth ____/____/____
Social Security # _____ E-mail _____ Primary Phone _____
Home Address _____ City _____ State _____ Zip Code _____
Employer _____ Business Phone _____
Do you have insurance with orthodontic benefits? Y ☐ N ☐ Name of insurance company _____

DENTAL/MEDICAL CONTACTS:

Family Dentist _____ Phone Number _____ Date of Last Exam ____/____/____
Physician _____ Phone Number _____
Emergency Contact Name _____ Relation _____ Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Safer Orthodontics. I understand that I am financially responsible for any balance. I also authorize Safer Orthodontics or my insurance company to release any information required to process my claims.

Signature of Patient/Guardian

Print Name

____/____/____
Date

Medical and Dental History Form

Allergies _____ Latex and/or Metal Allergy (please circle)

Medications or Drugs Currently Taking _____

Need for Antibiotic Prophylaxis for Heart Condition _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? (please circle) **Yes** or **No**

If yes, please explain: _____

Main orthodontic concern _____

Please circle **yes** or **no** to the following questions pertaining to the patient.

MEDICAL HISTORY:

Yes	No	Birth defects or hereditary problems?	Yes	No	Vision, hearing or speech problems?
Yes	No	Bone fractures or major injuries?	Yes	No	High or low blood pressure?
Yes	No	Injuries to face, head or neck?	Yes	No	Hemophilia?
Yes	No	Arthritis or joint problems?	Yes	No	Bruising or anemia?
Yes	No	Endocrine or thyroid problems?	Yes	No	Heart attack or stroke?
Yes	No	Diabetes or low sugar?	Yes	No	Chest pain or shortness of breath?
Yes	No	Kidney problems?	Yes	No	Skin disorder?
Yes	No	Cancer, tumor, or radiation therapy?	Yes	No	Frequent ear or throat infections?
Yes	No	Stomach ulcer, hyperacidity, acid reflux?	Yes	No	Asthma or sinus problems?
Yes	No	Immune system problems?	Yes	No	Tonsil or adenoid condition?
Yes	No	Sleep disorders?	Yes	No	Treated for mental health problems?
Yes	No	Hepatitis, jaundice or other liver problems?	Yes	No	AIDS or HIV positive?
Yes	No	Polio, mononucleosis, tuberculosis, pneumonia?	Yes	No	Hay fever or hives?
Yes	No	Seizures, fainting spells, neurologic problems?	Yes	No	Women: Are you pregnant?

DENTAL HISTORY:

Yes	No	Does the patient follow instructions?	Yes	No	Teeth extracted or missing?
Yes	No	Does the patient have learning disabilities?	Yes	No	Grind or clench teeth?
Yes	No	Speech therapy?	Yes	No	Injuries to the face, mouth or teeth?
Yes	No	Problems with previous dental treatment?	Yes	No	Sensitivity to heat, cold or sweets?
Yes	No	Ever been treated for TMJ problems?	Yes	No	Mouth breathing?
Yes	No	Previous orthodontic consultation or treatment?	Yes	No	Thumb or finger sucking habit?
Yes	No	Periodontal surgery or treatment?	Yes	No	Frequent headaches?
Yes	No	Oral Surgery?	Yes	No	Frequent canker sores or cold sores?

If yes to any of the above, please explain _____

I certify that the information given on this form is accurate. I will not hold any member of the Safer Orthodontics 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 medical or dental health.

Signature of Patient/Guardian

Print Name

Date