Safer Orthodontics, LLC

PATIENT REGISTRATION FORM

Today's Date: _____

Patient's Name_____Age_____ Date of Birth_____

Street Address_____City, State, Zip_____

Home Phone_____Cell_____

Work Phone_____Email_____

Best Method to Reach you: _____ Best Time to Reach You: _____

SS#_____Marital Status Single Married Divorced Widowed

Spouse's Name _____Spouse's Phone: (Work) _____(Cell) _____

School Currently Attending _____ Grade _____

Emergency Contact_____Relation_____Emergency Phone_____

Insurance Information

Person Responsible for Account_____Insurance Carrier_____

Group#_____ ID# _____ Phone_____

Subscriber's Name_____ Relation to Patient _____

Subscriber's SS# _____ Subscriber's Date of Birth_____

Employer/Co. Name _____Phone _____

Employer/Co. Address, City, State, Zip_____

Insurance Carrier Address, City, State, Zip_____

Who can we thank for referring you to our office? _____Patient's Dentist_____

Would you like to receive appointment reminders via text message? Yes No Cell Carrier_____

Would you like to receive appointment reminders via e-mail? Yes No

_____ _____ _____

Signature of Patient/Legal Guardian | Print Name | Date

Medical History

In order for us to provide you with the safest and best possible care, please complete this Medical & Dental History form. All information is kept strictly confidential.

Dental Information

Family Dentist _____ Phone_____Date of last exam_____
Reason for this Orthodontic visit_____

Please answer the following questions pertaining to the patient:

	Yes	No		Yes	No
Does the patient follow instructions?			Clicking or soreness when mouth is open?		
Does the patient have learning disabilities or need extra help with instructions?			Teeth extracted or missing?		
Any problems with previous dental treatment?			Injuries to the face, mouth or teeth?		
Ever been treated with "TMJ" problems (jaw joint and facial muscle pain)?			Grinding/clenching teeth?		
Previous orthodontic consultation or treatment?			Sensitivity to heat, cold or sweets?		
Periodontal surgery or treatment?			Home water supply fluoridated?		
Oral Surgery?			Frequent canker sores or cold sores?		
			Thumb or finger sucking habit?		

Medical Information

Physician Name_____ Phone_____

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?		
If yes, please explain_____		
Are you taking any prescription or over the counter medications?		
If yes, please list_____		

	Yes	No		Yes	No
Birth defects or hereditary problems?			Vision, hearing or speech problems?		
Bone fractures or major injuries?			High or low blood pressure?		
Any injuries to face, head or neck?			Excessive bleeding or bruising, anemia?		
Arthritis or joint problems?			Chest pain, shortness of breath, tire easily, swollen ankles?		
Endocrine or thyroid problems?			Heart defects, heart murmur, rheumatic heart disease?		
Diabetes or low sugar?			Cardiovascular problem (heart attack, angina)?		
Kidney Problems?			Skin disorder?		
Cancer, tumor, radiation treatment or chemotherapy?			Frequent headaches or migraines?		
Stomach ulcer, hyperacidity, acid reflux?			Frequent ear infections, colds, throat infections?		
Immune system problems?			Asthma, sinus problems, hay fever?		
History of osteoporosis?			Tonsil or adenoid condition?		
AIDS or HIV positive?			Do you frequently breathe through your mouth?		
Hepatitis, jaundice or other liver problems?			Sleep disorders?		
Polio, mononucleosis, tuberculosis, pneumonia?			Women: Are you pregnant?		
Seizures, fainting spells, neurologic problem?			Taking hormonal supplement?		
Mental health disturbance or depression?					

Have you had any allergies or reactions to any of the following?

Local anesthetics	Latex	Other antibiotics	Ibuprofen
Penicillin	Metals	Iodine	Aspirin

I certify that I have read and understand the above and that the information given on this form is accurate. I will not hold my orthodontist or any member of his 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/Legal Guardian | Print Name | Date