GRAND RIVER ORTHODONTICS

Comprehensive Patient Registration Record
And Health History
All information listed is
STRICTLY CONFIDENTIAL

Patient Information - Adult

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Gender: ☐ M ☐ F Birth Date: _____ Age: _____ Marital Status: _____

Spouse's Name (if applicable): _____ Email: _____

Phone (Home): _____ (Mobile): _____ (Work): _____ *Circle Preferred Contact #*

Address: _____
Street Apartment # City State Zip Code

Employer: _____ Occupation: _____

Name of your General Dentist: _____

Do you have family members that come to our office? _____

Who can we thank for referring you? _____

Name and relationship of emergency contact: _____

Phone number and alternative phone number of emergency contact: _____

Responsible Party Information

Name: _____

Gender: ☐ M ☐ F Relationship to you: _____ Birthdate: _____

Phone (Home): _____ (Mobile): _____ (Work): _____

Address: _____
Street Apartment # City State Zip Code

Previous Address (if at current address less than 3 years): _____
Street Apartment # City State Zip Code

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____ Years at this job: _____

Work Address: _____
Street Apartment # City State Zip Code

Insurance Information

Primary Dental Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group#: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Secondary Dental Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group#: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

Medical History

Please indicate whether or not you have ever had any of the following medical conditions by circling (Y)es or (N)o.

Y	N	ADD/ADHD	Y	N	Fainting or dizzy spells	Y	N	Lupus
Y	N	Anemia	Y	N	Fever blisters or herpes	Y	N	Migraine headaches
Y	N	Arthritis or joint swelling	Y	N	Gastrointestinal problems	Y	N	Neurologic problems
Y	N	Artificial bones/joints/valves	Y	N	Growth problems	Y	N	Organ donor
Y	N	Asthma	Y	N	Hearing impairment	Y	N	Organ transplant
Y	N	Blood disorder	Y	N	Heart attack or stroke	Y	N	Osteoporosis or weak bones
Y	N	Bone disorders	Y	N	Heart catheter/stent/pacemaker	Y	N	Persistent cough (>3wks)
Y	N	Cancer	Y	N	Heart murmur	Y	N	Radiation or chemotherapy
Y	N	Compromised immune system	Y	N	Hemophilia/prolonged bleeding	Y	N	Rheumatic/scarlet fever
Y	N	Congenital heart defect	Y	N	Hepatitis or liver problems	Y	N	Sickle cell disease/trait
Y	N	Convulsions/epilepsy/seizures	Y	N	High or low blood pressure	Y	N	Sinus problems
Y	N	Delayed or prolonged healing	Y	N	HIV/AIDS	Y	N	Skin disorder or rash
Y	N	Depression	Y	N	Hormone replacement	Y	N	Thyroid disease-hypo or hyper
Y	N	Diabetes	Y	N	Immunizations	Y	N	Tinnitus/ringing in the ear
Y	N	Drug/alcohol abuse	Y	N	Jaundice	Y	N	Tuberculosis
Y	N	Ear aches	Y	N	Kidney problems	Y	N	Vision problems
Y	N	Endocrine problems	Y	N	Learning disability	Y	N	Tonsils removed Age:____
Y	N	Emotional/psychological problems	Y	N	Lung disease	Y	N	Adenoids removed Age:____

Women only: Y N Are you pregnant?

Allergies: Y N Medications If yes, please list: _____

Y N Latex Y N Metals Y N Plastic/acrylic Y N Nuts, other foods, or dyes

Are you currently being seen for an injury or illness? Y N If yes, explain: _____

Have you ever been hospitalized? Y N If yes, explain: _____

Are there any other medical concerns we should be aware of? Y N If yes, explain: _____

Physician's Name: _____ Phone: _____ Date of last physical: _____

Please list any medication(s), prescription and over the counter, currently being taken along with the reason:

_____ Reason: _____

_____ Reason: _____

_____ Reason: _____

Dental History

Please indicate whether or not you have ever had any of the following by circling (Y)es or (N)o.

Y	N	Injury to the face, mouth, or teeth	If yes, explain _____
Y	N	Thumb, finger, or lip sucking habit	If yes, current or discontinued at what age? _____
Y	N	Tongue thrust problem	
Y	N	Mouth breathing	If yes, day, night, or both? _____
Y	N	Missing permanent teeth	
Y	N	Extra permanent teeth	
Y	N	Teeth removed by extraction	If yes, when? _____
Y	N	Clenching or grinding of teeth	If yes, day, night or both? _____
Y	N	Pain, popping, or locking on jaw opening or closing	
Y	N	Difficulty opening	
Y	N	Treatment for TMJ or jaw joint problems	If yes, explain _____
Y	N	Frequent headaches	
Y	N	Muscle tenderness or stiffness in the jaw or neck	
Y	N	Speech issues	
Y	N	Cleft lip and/or palate	
Y	N	Dry mouth	
Y	N	Abscess or cyst	
Y	N	Gum surgery	If yes, explain _____
Y	N	Periodontal disease	
Y	N	Dental emergencies	If yes, explain _____
Y	N	Previous orthodontic evaluation or treatment	If yes, explain _____

Date of last dental visit: _____ Date of last cleaning at your dentist: _____

What are your chief concerns and what would you like to accomplish with orthodontic treatment?

I understand that the information that I have given in the comprehensive patient registration record and health history is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in this information including changes in medical history, dental history, and medications. I will not hold anyone at Grand River Orthodontics responsible for any errors or omissions made in the completion of this form. I grant permission for my health care providers to be contacted when deemed necessary. This office reserves the right to verify credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. I have read and understood this paragraph and I authorize Grand River Orthodontics to perform a complete orthodontic evaluation (may include xrays and photographs as necessary at no charge).

Signature of patient Date