ADULT REGISTRATION

PATIENT INFORMATION:

Patient's Name: _____ Date:_____
Address:_____
Age:_____ Birthday:_____ Cell Phone #: _____
Employer: _____City:_____ Phone:_____
Married: _____ Single: _____ Divorced: _____ Spouses' Name: _____
Who may we thank for sending you to our office? _____

BILLING INFORMATION:

Person Responsible for the Account: _____ ss#: _____
Billing Address: _____
Phone #: _____ Employer: _____ City: _____
Work #: _____ **Dental** Insurance Company: _____
Address: _____ Phone #: _____

MEDICAL HISTORY:

Family Dentist: _____ City: _____
Physician's Name: _____ City: _____

Are there any general health problems?	YES	NO
Please specify _____		
Has the patient ever been hospitalized or had surgery?	YES	NO
Please specify _____		
Are medications being taken at this time?	YES	NO
Please list _____		
Has the patient had any of the following afflictions?		
HIV?	YES	NO
Heart disease?	YES	NO
Diabetes?	YES	NO
Rheumatic fever?	YES	NO
Epilepsy?	YES	NO
Respiratory disease?	YES	NO
Prolonged bleeding?	YES	NO
Hepatitis?	YES	NO
Allergy to any drugs?	YES	NO
Please list _____		
Healing complications?	YES	NO
Ear problems?	YES	NO
Nervous or mental disorder?	YES	NO
Kidney or liver disease?	YES	NO

CONSENT:

I grant Dr. Linda Powers permission to provide my dental exam and treatment. I will be responsible for the cost of this dental care including attorney fees and court cost that may be necessary to collect an outstanding balances on this account. In filing bankruptcy proceedings either voluntary or involuntary, Dr. Linda Powers reserves the right to terminate all future treatment and services.

Signed: _____ Date: _____

HISTORY

PATIENT MOTIVATION

What is the patient's chief complaint?

Crooked teeth Facial appearance Bite problems Spacing of front teeth
Joint problems Buck teeth Dentist sent me No idea Other_____

HABITS

Oro-digital habits? Thumb-sucking Finger-sucking Lip-biting

DENTAL HISTORY

Have any of the primary or permanent teeth been extracted? No Yes

Is there a history of accident or trauma to the teeth? No Yes

Periodontal (gum) problems? No Yes

Is the patient a smoker? No Yes

TMJ HISTORY

Does the patient clench or grind the teeth? If yes… clench grind

Pain upon opening, chewing, or headaches or earaches? No Yes
If yes: Which side? Right Left Both

Does the jaw lock upon opening or closing? No Yes

Limitations of movement of the jaw? No Yes

Clicking or popping? No Rare Infrequent Frequent
If yes: Which side? Right Left Both

ENVIRONMENT

Is there difficulty in breathing through the nose? No Yes

Have the tonsils and/or adenoids been removed? No Yes

Were there any major accidents, falls, trauma, or operations involving the head? No Yes

Is there a history of allergic conditions? If yes: Asthma Hay fever Other

CONGENITAL ANOMALIES If yes…

Cleft lip Cleft palate Congenital heart defects Other craniofacial anomalies (hand, feet)

GROWTH HISTORY (FEMALES ONLY)

Has menarche been reached (girls only)? Not known Irrelevant No Yes
If yes: At what age? _____

Are you taking any bisphosphonate medications (Aredia, Zometa, Boniva, etc)? No Yes

OTHER

Any other factors that you think may affect orthodontic treatment? _____