REGISTRATION SLIP

PLEASE PRINT

PATIENT'S NAME _____ SEX __ D.O.B. _____ S. S. #_____
Last First M. Initial mm - dd - yy

HOME ADDRESS _____ city zip _____ Home # _____

PREFERRED EMAIL ADDRESS _____ Patient's Cell # _____

IF MINOR, FATHER'S NAME_____ ADDRESS_____ Home #_____

Father's Cell # _____ Work #_____ Best Contact #_____

MOTHER'S NAME_____ ADDRESS _____ Home #_____

Mother's Cell # _____ Work #_____ Best Contact #_____

ALL BLANKS MUST BE COMPLETED:

PERSON FINANCIALLY RESPONSIBLE _____ RELATIONSHIP TO PATIENT_____

S.S.# _____ OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

PRIMARY DENTAL INSURANCE _____ INSURED NAME _____

INSURED S.S. # _____ D.O.B._____ POLICY NUMBER _____ GROUP # _____

SECONDARY DENTAL INSURANCE_____ INSURED NAME _____

INSURED S.S. # _____ D.O.B._____ POLICY NUMBER _____ GROUP # _____

NAME OF PHYSICIAN _____ PHONE # _____

NAME OF FAMILY DENTIST _____ ADDRESS _____ PHONE # _____

Circle "yes" or" no", to each item.

yes no RHEUMATIC FEVER
yes no ANEMIA
yes no ABNORMAL BLEEDING
yes no HEPATITIS: A, B, C, D, E, F, G
yes no ASTHMA
yes no IMMUNE SYSTEM DISORDERS(including AIDS,HIV,ARC)
yes no THYROID PROBLEMS
yes no FAINTING SPELLS OR SEIZURES
yes no GUMS BLEED WHILE BRUSHING?
yes no GUMS BLEED WHILE FLOSSING?
yes no ANY HEAD, NECK, OR JAW INJURIES?
yes no FREQUENT HEADACHES?
yes no CLENCH OR GRIND WHILE AWAKE OR ASLEEP?
yes no ANY ARTIFICIAL JOINT, IMPLANT, VALVE, etc.
(If yes, specify)_____
yes no HEART (SURGERY, DISEASE, ATTACK, ETC.)
yes no HEART MURMUR
If yes: Explain _____
: Need pre-medication before dental procedures? _____

yes no ARE YOU PREGNANT?
yes no ALLERGIC TO PENICILLIN
yes no ALLERGIC TO OTHER ANTIBIOTICS (specify)_____
yes no ALLERGIC TO LOCAL ANESTHETIC
yes no ALLERGIC TO PLASTIC OR LATEX
yes no ALLERGIC TO OTHER (If yes, specify)_____
yes no PROLONG COUGH 3-4 WEEKS
yes no UNEXPLAINED WEIGHT LOSS
yes no NIGHT SWEATS
yes no ACTIVE TUBERCULOSIS
yes no CLICKING IN YOUR JAW JOINTS
yes no PAIN (Joint, ear, side of face)?
yes no DIFFICULTY IN OPENING OR CLOSING?
yes no DIFFICULTY IN CHEWING?
yes no ANY TREATMENT FOR YOUR JAW JOINTS?
yes no ANY HISTORY OF HERPES, COLD SORES, FEVER BLISTERS?
yes no NERVOUS DISORDER

Are you taking any medicine(s) or on any therapy? ____If yes, please list and state purpose of medicine or therapy_____

Other physical conditions, diseases or addictions? Please list and explain: _____

Referred By:_____Reason For Visit: _____

Have You Ever Had Any Previous Orthodontic Treatment?_____ If yes, please explain_____

When Was Your Last Cleaning? _____

When Was Your Last Full Mouth X-ray Taken And Where? _____

How Often Do You Brush Each Day?_____ Floss Each Day? _____

Have You Or Any Other Family Members Been Seen At Our Office Before? _____

If yes, please list names_____

Is There Any Other Information That The Doctor Should Know? _____

I attest to the fact that the above information is correct to the best of my knowledge.

SIGNATURE OF PATIENT OR PARENT IF MINOR _____ _____ DATE_____
Relationship to patient

SIGNATURE OF DOCTOR _____ DATE _____