

REGISTRATION SLIP

PLEASE PRINT

PATIENT'S NAME _____ SEX _____ D.O.B. _____ S. S. # _____
Last First M. Initial

HOME ADDRESS _____ city _____ zip _____ Phone # _____

IF MINOR, FATHER'S NAME _____ ADDRESS _____ Patient's Cell # _____
Home # _____

Father's Cell # _____ Work # _____

MOTHER'S NAME _____ ADDRESS _____ Home # _____

Mother's Cell # _____ Work # _____

PATIENT'S OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

PERSON FINANCIALLY RESPONSIBLE _____ RELATIONSHIP TO PATIENT _____

S.S.# _____ OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ BUSINESS PHONE # _____

PRIMARY DENTAL INSURANCE _____ INSURED NAME _____

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

SECONDARY DENTAL INSURANCE _____ INSURED NAME _____

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

NAME OF PHYSICIAN _____ PHONE # _____

NAME OF FAMILY DENTIST _____ ADDRESS _____ PHONE # _____

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

- | | | | | | |
|-----|----|---|-----|----|---|
| yes | no | RHEUMATIC FEVER | yes | no | ARE YOU PREGNANT? |
| yes | no | ANEMIA | yes | no | ALLERGIC TO PENICILLIN |
| yes | no | ABNORMAL BLEEDING | yes | no | ALLERGIC TO OTHER ANTIBIOTICS (specify) _____ |
| yes | no | HEPATITIS: A, B, C, D, E, F, G | yes | no | ALLERGIC TO LOCAL ANESTHETIC |
| yes | no | ASTHMA | yes | no | ALLERGIC TO PLASTIC OR LATEX |
| yes | no | IMMUNE SYSTEM DISORDERS(including AIDS,HIV,ARC) | yes | no | ALLERGIC TO OTHER (If yes, specify) _____ |
| yes | no | THYROID PROBLEMS | yes | no | PROLONG COUGH 3-4 WEEKS |
| yes | no | FAINTING SPELLS OR SEIZURES | yes | no | UNEXPLAINED WEIGHT LOSS |
| yes | no | GUMS BLEED WHILE BRUSHING? | yes | no | NIGHT SWEATS |
| yes | no | GUMS BLEED WHILE FLOSSING? | yes | no | ACTIVE TUBERCULOSIS |
| yes | no | ANY HEAD, NECK, OR JAW INJURIES? | yes | no | CLICKING IN YOUR JAW JOINTS |
| yes | no | FREQUENT HEADACHES? | yes | no | PAIN (Joint, ear, side of face)? |
| yes | no | CLENCH OR GRIND WHILE AWAKE OR ASLEEP? | yes | no | DIFFICULTY IN OPENING OR CLOSING? |
| yes | no | HEART MURMUR (If yes, explain) _____ | yes | no | DIFFICULTY IN CHEWING? |
| yes | no | HEART (SURGERY, DISEASE, ATTACK, ETC.) | yes | no | ANY TREATMENT FOR YOUR JAW JOINTS? |
| yes | no | Need Pre-medication Before Dental Procedures? | yes | no | ANY HISTORY OF HERPES, COLD SORES,
FEVER BLISTERS? |
| yes | no | ANY ARTIFICIAL JOINT, IMPLANT, VALVE, etc.
(If yes, specify) _____ | 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 _____

SIGNATURE OF DOCTOR _____ Relationship to patient _____ DATE _____