



ORTHODONTICS FOR ADULTS AND CHILDREN

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ORTHODONTIC LICENSE #5286

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**ADULT REGISTRATION AND HEALTH HISTORY**

Registration form with fields for Name, Social Security Number, Birthdate, Home Phone, Business Phone, Address, City, State, Zip, Employed by, Present position, Spouse/partner's name, Spouse/partner's Social Security Number, Spouse/partner's birthdate, Spouse/partner's driver license no., Referred by, Address.

Who will pay this account?

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will be not released to anyone without your written permission.

**YOUR DENTAL HISTORY**

Are you having any discomfort at this time? How long since you have been to a dentist? Did you have X-Rays? How often did you visit a dentist before then? Have you lost any teeth? Why? Any complications with extractions? Have they ever been replaced by: (1) A Fixed Bridge (2) Removable Partial (3) Denture? How many of (1) (2) (3)? Are your teeth sensitive to heat to cold to sweets to sour? Have you had your teeth straightened? When? How often do you brush your teeth? When? How?

How long do you use a toothbrush before replacing it? Do you use dental floss? How often? Between-the-teeth stimulator? Water jet? Do you have bleeding gums? When? Do you eat between meals? Do you brush teeth after snacks? Does food wedge between your teeth? Where? Do you grind or clench your teeth? When? Have you ever had gum treatments? When? Do you feel you have bad breath at times? Unpleasant taste in mouth? Any pain in or around your ears? Do you hear popping, clicking or snapping noises when you chew? Do you have any nasal obstructions? Are you aware of any swelling or lump in your mouth?

Other side, please

Do you now have or have you had any of the following habits: Thumbsucking \_\_\_\_\_ Fingersucking \_\_\_\_\_

Cheek or tongue chewing \_\_\_\_\_ Chewing on Pencils \_\_\_\_\_ Pens \_\_\_\_\_ Lip \_\_\_\_\_ Fingernails \_\_\_\_\_

Tobacco use \_\_\_\_\_ Alcohol use \_\_\_\_\_

Do you any fear of having dentistry done \_\_\_\_\_

If yes, why \_\_\_\_\_

How do you feel about your teeth \_\_\_\_\_

### **MEDICAL HISTORY**

Physician's name \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Do you have or have you had any of the following? Please indicate with Check Mark (✓)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Any heart problems       | <input type="checkbox"/> Allergies to medicines or drugs | <input type="checkbox"/> Eating Disorder  | <input type="checkbox"/> Scarlet Fever    |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Allergies to: _____             | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> Low blood pressure       | _____  | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Circulatory problems     | _____  | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Nervous problems         | _____  | <input type="checkbox"/> Malignancies     | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Radiation treatments     | _____  | <input type="checkbox"/> Measles          | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Excessive bleeding       | <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Mumps            | <input type="checkbox"/> Ulcer            |
| <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Other            |

Are you pregnant \_\_\_\_\_ Blood Pressure: S \_\_\_\_\_ / D \_\_\_\_\_ / \_\_\_\_\_

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

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Date: \_\_\_\_\_ Your Signature \_\_\_\_\_