
Adult New Patient Registration...

(for patients over age 18)

Today's Date _____

Patient Name _____

Preferred Greeting/Nickname _____ Age _____ Birthday _____

Home Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address *(only used for reminders and updates)* _____

Occupation _____ Employed By _____

Spouse's Name _____ Spouse's Work Phone _____

Spouse's Occupation _____ Spouse Employed By _____

Emergency Contact *(non-relative, not living with you):* _____ Phone _____

Primary Care Dentist _____ Primary Care Physician _____

In your opinion, what is your top orthodontic concern/problem? _____

Who may we thank for referring you to our office? _____

Person Responsible for Account _____

Social Security # _____ Birthday _____ Age _____ Sex M F

Address _____ City/State/Zip _____

Do you have orthodontic insurance coverage? Yes No Company _____

Group/Policy Number _____ Phone Contact _____



Dental/Medical Health Questionnaire...

Today's Date _____

Patient Name _____ Birthday _____

Primary Care Dentist _____ Date of Last Visit _____

Have you ever had the following dental treatment?

- Orthodontics... Dates: _____ Doctor: _____
Periodontal Treatment ("gum" surgery/treatment)... Doctor: _____
Mouthguard/Splint Therapy (for jaw joint problems)...
Jaw Surgery to change your bite or correct jaw joint...

Do you have or have you ever had any of the following oral conditions?

- Sensitive Teeth, Bleeding Gums, Food Wedging/Impaction, Clenching/Grinding, Pain Around Ear, Swelling or Lumps in Mouth, Bad Breath, Mouth-breathing, Tobacco Use, Pain in the Face/Jaw, Thumb/Finger-sucking Habit, Jaw Joint Sounds/Pain, Dry Mouth, Painful Opening, Difficulty Flossing Between Teeth, Poorly Functioning Teeth, Discolored Teeth, Jaw gets Stuck (open or closed)

Have or ever had any of the following medical conditions?

- Columns of medical conditions with 'Y' and 'N' checkboxes: Rheumatic Fever, Diabetes, Inflammatory Rheumatism, Asthma, Liver Disease, Severe Headaches, Eye Problems, Nose Bleeds, Easy Bruising, ADD/ADHD, Congenital Heart Lesions/Murmur, Anemia, Kidney Problems, Yellow Jaundice, High Blood Pressure, Dizziness or Fainting, Ear Problems, Speech Problems, Venereal Disease, Heart Condition, Arthritis, Swollen Joints, Tuberculosis, Hepatitis (Type _____), Low Blood Pressure, Convulsions or Seizures, Sinus Problems, Swallowing Problems, HIV Positive, Other (not listed)

Currently under the care of a physician? _____ Yes No

Ever been hospitalized or treated for a serious illness? _____ Yes No

Any drug allergies? If yes, please list medications. _____ Yes No

Any allergies to metal, latex, or vinyl products? If yes, please explain. _____ Yes No

Currently taking any medications? If yes, please list them. _____ Yes No

Female Patients: Is there any possibility of pregnancy at the present time? _____ Yes No

Ever taken any diet medication (Phen-Fen)? _____ Yes No

Patient/Parent/Guardian Signature _____ Date _____

Dr. Seth's Signature _____

Additional Notes: _____