Welcome!

Adult Registration Form

Whom may we thank for referring you to our office? _____
Have we treated any of your family or friends? _____

Patient Information
(Please Print)

Name _____ Gender _____ Date _____
First Middle Last

Address _____ City _____ State ___ Zip _____

Home Phone # _____ Work # _____ Cell #_____

How long at this address? _____

Birth Date _____ Age ____ SS# _____ Are you □ Single □ Married □ Divorced □ Separated □Widowed

Your place of Employment: _____

Your Employer's Address _____ City _____ State ___ Zip _____

Occupation _____ How Long?_____

*Emergency Contact: Name*_____ *Phone#*_____

Dental History

What dental problem brings this patient to my office? _____
Is there anything in particular that you would like to change about your smile? _____

Patient's Dentist _____ How long/Often? _____

Does patient have a history *any* of the following?

□ Previous orthodontic treatment	□ Bleeding gums	□ Speech problems	□ Mouth sores
□ Mouth/Face injuries	□ Periodontal care	□ Difficulty Chewing	□ Chin Scar
□ Thumb/Finger sucking	□ Mouth breather	□ Snore while sleeping	□ Teeth grinding
□ Clicking/popping in jaw	□ Jaw pain	□ Pain around the ear /Earaches	□ Headaches

If you checked *any* of the above, please explain: _____

Medical History

Primary Care Physician _____ Date of last visit _____

Please list *all* medications patient is currently taking: _____

Known allergies: _____

Current medical treatment and past hospitalizations: _____

Does the patient have any other medical condition that we should be aware of? _____

(Woman) Is patient pregnant? □ Yes □ No Taking birth control? □ Yes □ No

Does patient have a history of any of the following?

□ Allergies	□ Blood disease	□ Hearing Disorder	□ Rheumatic Fever
□ Anemia	□ High/low blood pressure	□ Heart Murmur	□ Seizure disorder
□ Arthritis or Rheumatism	□ Cancer	□ Hepatitis	□ Sleeping Disturbances
□ Artificial Heart Valves	□ Cough, persistent	□ HIV positive	□ Stroke
□ Asthma	□ Diabetes	□ kidney disease	□ Thyroid Problems
□ Autoimmune disorder	□ Dizziness/Fainting	□ Liver Disease	□ Tobacco Habit
□ Back problems	□ Emotional Problems	□ Psychiatric Care	□ Tonsillitis
□ Other _____			

If you checked *any* of the above, please explain: _____

Patient's interest in orthodontic care: □Wants treatment □Only if necessary □Unwilling but agrees □Minimal

Orthodontic consultation prompted by: □Patient □Dentist □Family Member □Physician □Friend □ Other

What are some of your final treatment goals:

□ Beautiful smile	□ Evenly aligned teeth	□ Healthy bite	□ Long term stability
□ Ease of treatment	□ Improve facial proportions	□ Correct overbite	□ Eliminate crowding
□ Close spaces	□ Improve facial appearance	□ Eliminate pain	□ Short treatment time

□ Other_____

Billing Party Information

(Complete only if the person responsible for the account is not the patient)

Name _____ SS# _____
First Middle Last

Address _____ City _____ State ____ Zip _____

Place of Employment _____ How Long? _____

Employer's Address _____ City _____ State ____ Zip _____

Occupation _____ Work # _____ Cell #_____

Dental Insurance Information

Insurance Company _____ Employer _____

Policy Holder _____ Date of Birth _____ SS #_____

Group # _____ ID # _____ Phone # _____

Address _____ City _____ State ____ Zip _____

Our preferred method of communicating is via email. What email address can we use for:
Account/Statements _____

Appointments _____

I give permission to discuss my treatment with the following:

*Name*_____ *Relationship to patient*_____

*Name*_____ *Relationship to patient*_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions on both pages have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the orthodontist to release any information including the diagnosis and records of any treatment or examination rendered to me during the period of such dental care to third party payer and/or health practitioners. I understand this may include the release of information concerning HIV testing, diagnosis, or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, any psychiatric and/or psychological conditions. I agree to be responsible for payment of all services rendered on my behalf. I understand that any balance carried on the house accounts after thirty (30) days from the date of service, will be charged interest on the unpaid balance at 1 ½ percent per month, compounded monthly, at an annual percentage rate of 18%. I understand that I am subject to credit checks before and/or during the course of treatment (includes new and current patients).

_____ _____
Signature of Patient Date

Acknowledgement of receipt of notice of privacy practices

I have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature of Patient Date