WELCOME TO OUR PRACTICE!

ADULT REGISTRATION AND HEALTH HISTORY Today's Date _____

PATIENT INFORMATION Birth Date _____ Age _____

First Name _____ Last Name _____ Nickname _____

Address _____ City _____ State _____ Zipcode _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status (please circle): Single Married Partners Divorced Separated Widow(er)

Employer _____ Occupation _____

Email Address _____

Who will be responsible for the payments of this account? _____

Responsible Party Address _____ Phone _____

Whom may we thank for referring you? _____

In case of emergency, whom should we contact? _____ Phone _____

Please describe your orthodontic concerns _____

PRIMARY DENTAL INSURANCE (if applicable)

Policy Holder's Full Name _____ Birth Date _____ SSN _____

Insurance Company _____ Group # _____

Employer Name and Address _____

SECONDARY DENTAL INSURANCE (if applicable)

Policy Holder's Full Name _____ Birth Date _____ SSN _____

Insurance Company _____ Group # _____

Employer Name and Address _____

DENTAL HISTORY

Name and Address of Family Dentist _____ Date of Last Visit _____

Do you have any dental work that needs to be finished by your dentist? If yes, describe_____
Do you need to be premedicated for dental visit? If yes, describe_____
Have you had permanent teeth removed? If yes, describe_____
Have you been seen by an orthodontist previously? If yes, describe_____
Do you have or ever had any of the following: (Please Circle)

Bleeding, Sore gums	Difficulty opening / closing jaw	Missing teeth / Extra teeth
Unpleasant Taste / Bad Breath	Clicking / Popping jaw	Gum Disease / Loose teeth / Bone Loss / Recession
Frequent Blisters (mouth/lips)	Food Impaction	Injury to mouth, teeth, or head
Biting Cheek / Lips	Sensitive to hot/cold/sweets	Clenching / Grinding (if so, when _____)
Previous Ortho treatments/Braces	Dry Mouth / Mouth Breather	History of Thumb or Finger Sucking Habit
Mouth / Jaw Pain or Soreness	Periodontal (Gum) Treatment	Speech Problems

Other _____

Please complete other side

MEDICAL HISTORY

Name and Address of Physician _____ Phone _____

Are you currently under any medical treatment? …….. If yes, describe _____
Have you ever had surgery or been hospitalized? …… If yes, describe _____
Are you currently taking any medications? …… If yes, describe _____
Are you allergic to Penicillin or other medications, foods, latex, etc.? …….. If yes, describe _____
Do you smoke?_____ Do you use alcohol? _____ *Women Only*: Are you pregnant? _____

Have you ever had a history of or difficulty with any of the following: (Please Circle)

Anemia	Epilepsy	Jaundice	Polio	Diabetes
Anorexia	Emphysema	Kidney Problems	Prosthetic Valves/Joints	HIV/AIDS
Asthma	Fainting	Liver Problems	Prostate Problems	High Blood Pressure
Arthritis	Glaucoma	Latex Allergy	Respiratory Disease	Hormonal Problems
Artificial Joints	Hearing Problems	Emotional Problems	Rheumatic Fever	Respiratory Disease
Bleeding Tendency	Hernia	Mononucleosis	Scarlet Fever	Ulcers
Back Problems	Heart Defects	Measles	Shortness of Breath	Tonsilitis
Blood Disease	Heart Murmur	Migraines/Headaches	Sinus Trouble	Tuberculosis
Chemical Dependency	Heart Disease	Mitral Valve Prolapse	Skin Rash	Pneumonia
Cancer	Hepatitis (Type___)	Mumps	Stroke	Pacemaker
Cerebral Palsy	Herpes (fever blisters)	Multiple Sclerosis	Thyroid Problems	Convulsions
Chicken Pox	Sleep Apnea	Bisphosphonate Threrapy	Other _____	

ASSIGNMENT AND CONSENT

I hereby authorize payment directly to Dr. M. Marie Dang for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance company, and for all services rendered on my behalf and/or my dependents. I authorize the Doctor and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and understand the above history questionnaire. If there are subsequent changes to this history record or medical/dental status, I will inform this practice. I also authorize the Doctor to perform the necessary diagnostic procedures to make a thorough diagnosis of the patients' dental and oral-facial needs, including x-rays, study models, and photographs.

Signature of Responsible Party _____ Date _____

Signature of Doctor _____ Date _____

MEDICAL/DENTAL UPDATES **(To be completed at future appointments)**

Are there any changes in your health? If yes, please describe _____

Are you taking any new medications? If yes, please describe _____

Has there been a change in your dentist or physician? If yes, please indicate _____

Signature of Responsible Party _____ Date _____

Signature of Doctor _____ Date _____

Are there any changes in your health? If yes, please describe _____

Are you taking any new medications? If yes, please describe _____

Has there been a change in your dentist or physician? If yes, please indicate _____

Signature of Responsible Party _____ Date _____

Signature of Doctor _____ Date _____