

Safer Orthodontics, LLC
PATIENT REGISTRATION FORM

Today's Date: _____

Patient's Name _____ Age _____ Date of Birth _____

Street Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Work Phone _____ Email _____

Best Method to Reach you: _____ Best Time to Reach You: _____

SS# _____ Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name _____ Spouse's Phone: (Work) _____ (Cell) _____

School Currently Attending _____ Grade _____

Emergency Contact _____ Relation _____ Emergency Phone _____

Insurance Information

Person Responsible for Account _____ Insurance Carrier _____

Group# _____ ID# _____ Phone _____

Subscriber's Name _____ Relation to Patient _____

Subscriber's SS# _____ Subscriber's Date of Birth _____

Employer/Co. Name _____ Phone _____

Employer/Co. Address, City, State, Zip _____

Insurance Carrier Address, City, State, Zip _____

Who can we thank for referring you to our office? _____ Patient's Dentist _____

Would you like to receive appointment reminders via text message? ☐ Yes ☐ No Cell Carrier _____

Would you like to receive appointment reminders via e-mail? ☐ Yes ☐ No

Signature of Patient/Legal Guardian

Print Name

Date

Medical History

*In order for us to provide you with the safest and best possible care, please complete this Medical & Dental History form.
All information is kept strictly confidential.*

Dental Information

Family Dentist _____ Phone _____ Date of last exam _____
Reason for this Orthodontic visit _____

Please answer the following questions pertaining to the patient:

	Yes	No		Yes	No
Does the patient follow instructions?	☐	☐	Clicking or soreness when mouth is open?....	☐	☐
Does the patient have learning disabilities or need extra help with instructions?	☐	☐	Teeth extracted or missing?.....	☐	☐
Any problems with previous dental treatment?.....	☐	☐	Injuries to the face, mouth or teeth?.....	☐	☐
Ever been treated with "TMJ" problems (jaw joint and facial muscle pain)?.....	☐	☐	Grinding/clenching teeth?.....	☐	☐
Previous orthodontic consultation or treatment?.....	☐	☐	Sensitivity to heat, cold or sweets?.....	☐	☐
Periodontal surgery or treatment?.....	☐	☐	Home water supply fluoridated?.....	☐	☐
Oral Surgery?.....	☐	☐	Frequent canker sores or cold sores?.....	☐	☐
			Thumb or finger sucking habit?.....	☐	☐

Medical Information

Physician Name _____ Phone _____
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....
If yes, please explain _____
Are you taking any prescription or over the counter medications?.....
If yes, please list _____

	Yes	No		Yes	No
Birth defects or hereditary problems?.....	☐	☐	Vision, hearing or speech problems?.....	☐	☐
Bone fractures or major injuries?.....	☐	☐	High or low blood pressure?.....	☐	☐
Any injuries to face, head or neck?.....	☐	☐	Excessive bleeding or bruising, anemia?.....	☐	☐
Arthritis or joint problems?.....	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?.....	☐	☐
Endocrine or thyroid problems?.....	☐	☐	Heart defects, heart murmur, rheumatic heart disease?.....	☐	☐
Diabetes or low sugar?.....	☐	☐	Cardiovascular problem (heart attack, angina)?.....	☐	☐
Kidney Problems?.....	☐	☐	Skin disorder?.....	☐	☐
Cancer, tumor, radiation treatment or chemotherapy?.....	☐	☐	Frequent headaches or migraines?.....	☐	☐
Stomach ulcer, hyperacidity, acid reflux?.....	☐	☐	Frequent ear infections, colds, throat infections?....	☐	☐
Immune system problems?.....	☐	☐	Asthma, sinus problems, hay fever?.....	☐	☐
History of osteoporosis?.....	☐	☐	Tonsil or adenoid condition?.....	☐	☐
AIDS or HIV positive?.....	☐	☐	Do you frequently breathe through your mouth?....	☐	☐
Hepatitis, jaundice or other liver problems?.....	☐	☐	Sleep disorders?.....	☐	☐
Polio, mononucleosis, tuberculosis, pneumonia?.....	☐	☐	Women: Are you pregnant?.....	☐	☐
Seizures, fainting spells, neurologic problem?.....	☐	☐	Taking hormonal supplement?.....	☐	☐
Mental health disturbance or depression?.....	☐	☐			

Have you had any allergies or reactions to any of the following?

Local anesthetics	Latex	Other antibiotics	Ibuprofen
Penicillin	Metals	Iodine	Aspirin

I certify that I have read and understand the above and that the information given on this form is accurate. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature of Patient/Legal Guardian

Print Name

Date