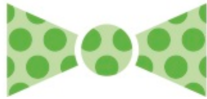
DAVIS
ORTHODONTICS



New Patient Registration
For Our Adult Patients

Patient Information

Last Name_______________ First Name________________ Middle Initial____ Preferred Name_______________
Date of Birth________________ Age______ Gender: M☐ F☐ Social Security Number____________________
Home Address__________________________________ City__________________ State_____ Zip_______________
Home Phone__________________ Cell Phone____________________ Cell Carrier__________________________
Family Dentist___________________ Family Physician_________________ Email___________________________
Employer______________________________________ Occupation______________________________________
Marital Status: ___Married ___Single ___Divorced ___Widowed Emergency Contact Person_______________
Children:
Name___________________ Birthdate__________ Name_____________________ Birthdate__________
Name___________________ Birthdate__________ Name_____________________ Birthdate__________

Who/Whom may we thank for referring you to our office?____

Family Information

Spouse's Name_________________________ Date of Birth______________ Social Security Number____________
Spouse's Address______________________________________ City________________ State____ Zip___________
Home Phone______________________ Cell Phone____________________ Cell Carrier_______________________
Employer__________________________________ Occupation____

Responsible Party Information

Who is the person responsible for the patient's account? Self☐ Spouse☐ Other ☐ (please see below for other)
Other's Name_________________________ Date of Birth______________ Social Security Number____________
Other's Address (if different from patient's)___________________________ City____________State___ Zip_____
Home Phone______________________ Cell Phone____________________ Cell Carrier______________________
Employer__________________________________ Relationship to Patient__________________________________

Orthodontic/Dental Insurance Information

Primary Dental Insurance: Does the patient have primary orthodontic coverage? Yes☐ No☐
Insured's Name________________________________ Relationship to Patient_____________________________
Social Security Number__________________ Date of Birth________________ Employer______________________
Dental Insurance Carrier____________________________ Group/ID Number______________________________

Secondary Dental Insurance: Does the patient have secondary orthodontic coverage? Yes☐ No☐
Insured's Name________________________________ Relationship to Patient_____________________________
Social Security Number__________________ Date of Birth________________ Employer______________________
Dental Insurance Carrier____________________________ Group/ID Number______________________________

Health Questionnaire

Medical History

☐Yes ☐No Is the patient in good health? If no, please explain____________________

☐Yes ☐No Is the patient currently being treated by a physician? If yes, please explain____________________

☐Yes ☐No Any previous hospitalization or serious illness? If yes, please explain____________________

☐Yes ☐No Is the patient allergic to latex?

☐Yes ☐No Is the patient allergic to any medications? If yes, please list:____________________

☐Yes ☐No Is the patient taking any medications? If yes, please list:____________________

Does the patient now, or have they ever had a history of any of the following (Mark Y for Yes or N for No):

☐Y ☐N Rheumatic Fever
☐Y ☐N Asthma
☐Y ☐N Severe Headaches
☐Y ☐N Easy Bruising
☐Y ☐N Kidney Problems
☐Y ☐N Yellow Jaundice
☐Y ☐N Ear Problems
☐Y ☐N Heart Condition
☐Y ☐N Hepatitis type ___
☐Y ☐N Sinus Problems
☐Y ☐N Bisphosphonate Treatment
☐Y ☐N Diabetes
☐Y ☐N Lung Disease
☐Y ☐N ADD/ADHD
☐Y ☐N Nose Bleeds
☐Y ☐N Anemia
☐Y ☐N High Blood Pressure
☐Y ☐N Speech Problems
☐Y ☐N Arthritis
☐Y ☐N Low Blood Pressure
☐Y ☐N Swallowing Problems
☐Y ☐N Tumor/Cancer
☐Y ☐N Joint Replacement
☐Y ☐N Liver Disease
☐Y ☐N Tuberculosis
☐Y ☐N Eye Problems/Glaucoma
☐Y ☐N Congenital Heart Defect
☐Y ☐N Dizziness or Fainting
☐Y ☐N Venereal Disease
☐Y ☐N Thyroid Problems
☐Y ☐N Convulsions/Seizures
☐Y ☐N HIV Positive
☐Y ☐N Bone Disorders

Females Only:

☐Yes ☐No Is it possible that the patient may be pregnant?

☐Yes ☐No Has menstruation begun? If yes, when did it begin?____________________

☐Yes ☐No Are there any medical conditions we have not discussed that you feel we should be aware of?
If yes, please explain____________________

Dental History

Does the patient have a chief concern about their teeth?____________________

Date of most recent dental examination:____________________

☐Yes ☐No Has the patient had a previous orthodontic exam? If so, when____________________

☐Yes ☐No Has the patient had previous orthodontic treatment? If so, when____________________

☐Yes ☐No Has the patient's adenoids and/or tonsils been removed?

Does the patient now, or have they every had a history of any of the following (Mark Y for Yes or N for No):

☐Y ☐N Injury to the Teeth/Jaws
☐Y ☐N Grinding
☐Y ☐N Sleep Apnea
☐Y ☐N Finger/Thumb Sucking
☐Y ☐N Headaches/Earaches
☐Y ☐N Sensitive Teeth
☐Y ☐N Nail Biting
☐Y ☐N Joint Pain
☐Y ☐N Gum Disease
☐Y ☐N Mouth Breathing
☐Y ☐N Tongue Thrust
☐Y ☐N Tobacco Use
☐Y ☐N Joint Clicking/Popping
☐Y ☐N Snoring
☐Y ☐N Jaw Growth Disorder
☐Y ☐N Speech Problems
☐Y ☐N Missing Teeth
☐Y ☐N Extra Teeth

Please elaborate on any items that were circled:____________________

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. This office will not be held responsible for any problems arising out of inadequate information no disclosed. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I authorize the Orthodontist to share this patient's treatment information with the collaborating dentists and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

____________________ ____________________ | ____________________

Signature of patient, guardian or responsible party Date Doctor's Initials