Registration and History

1 Adult Patient Information

Date ______________________

Patient ______________________

Address ______________________

City/State/Zip ______________________

Sex: ☐ M ☐ F Age ______ Birthdate ______________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer ______________________

Business Address ______________________

Work Phone ______________________

Spouse's Name ______________________

Employer ______________________

Business Address ______________________

Work Phone ______________________

2 Account/Insurance/Information

*If you have insurance, please supply us with a copy of your insurance card.

Who is responsible for this account? ______________________

Relationship to Patient ______________ SS # ______________

Address ______________________

Home Phone ______________ Work Phone ______________

Is patient covered under Ortho insurance? ☐ Yes ☐ No

Subscriber's Name ______________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________

Insurance Co. ______________________

Group # ______________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Dr. Sikora all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

______________________ ______________
Relationship Date

3 Emergency Information

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______________________ Relationship ______________________

Home Phone ______________________ Work Phone ______________________

4 Dental History

Dentist Name ______________________ Referred By ______________________

How many times per year does your dentist examine the patient's teeth.......................... ______________

Approximate date of last visit ______________

Is the patient concerned about the appearance of his/her teeth .... ☐ Yes ☐ No

Has any other member of the family had orthodontic treatment.. ☐ Yes ☐ No

Has the patient ever received a severe blow to the teeth or jaws.. ☐ Yes ☐ No

Does the patient have any problems with sore gums .... ☐ Yes ☐ No

Does the patient have any of the following habits:

Grinding teeth at night ☐ Yes ☐ No Clenching teeth ☐ Yes ☐ No

Has the patient ever experienced clicking/locking/limited opening of the jaw joint.............. ☐ Yes ☐ No

Has the patient had previous orthodontic treatment .... ☐ Yes ☐ No

Who first noticed the need for orthodontic treatment ☐ Dentist ☐ Patient

What is the patient's chief concern ______________________

____

____

____

– O V E R –

#15131 — ©Medical Arts Press® 1-800-328-2179

Health History

Physician's Name____________________ Date of last visit____________

- Is the patient currently under a physician's care .... ☐ Yes ☐ No
- Has the patient ever been hospitalized .... ☐ Yes ☐ No
- Is the patient receiving any medication .... ☐ Yes ☐ No
- Has the patient ever had surgery .... ☐ Yes ☐ No
- Are there any emotional problems .... ☐ Yes ☐ No
- Was the patient absent from school or work for more than 5 days last year due to illness .... ☐ Yes ☐ No
- Has the patient ever had an unusual reaction to any drug such as penicillin, local anesthetics, or antibiotics .... ☐ Yes ☐ No
- Does the patient have any other allergies (including reactions to jewelry or latex) .... ☐ Yes ☐ No
- Does the patient have damaged heart valves, artificial heart valves or congenital heart lesions, including heart murmur, or artificial joints .... ☐ Yes ☐ No
- Has the patient ever taken the appetite suppressant drugs fenfluramine (Pondimin) or dexphenfluramine (Redux) either alone or in combination with phentermine, commonly known as fen-phen .... ☐ Yes ☐ No
- Does the patient have any condition for which a physician or dentist has prescribed antibiotics to be taken prior to a dental procedure .... ☐ Yes ☐ No
- Does the patient have any physical limitations that affect motor coordination .... ☐ Yes ☐ No

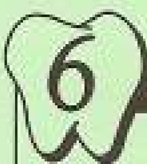
**If the answer to any of the above questions is YES, please explain:

____

____

If the patient has had any history or difficulty with any of the following, please check:

☐ Anemia	☐ Chronic Sinus	☐ HIV
☐ Arthritis/Joint Inflammation	☐ Convulsions	☐ Immune Disorder
☐ Asthma	☐ Diabetes	☐ Kidney Disorder
☐ Bladder Disorder	☐ Epilepsy	☐ Liver Disorder
☐ Blood Clotting Disorder	☐ Fainting	☐ Malignancies
☐ Cerebral Palsy	☐ Hearing Disorder	☐ Rheumatic Fever
☐ Tuberculosis	☐ Heart Disorder	☐ Thyroid Disorder
		Other____________



Updates (To be filled in at future appointments)

Has there been any change in your health since your last orthodontic appointment? ☐ Yes ☐ No

For what conditions?____________________

Are you taking any new medications?____________ If so, what____________________

Patient's Signature____________________ Date____________

Has there been any change in your health since your last orthodontic appointment? ☐ Yes ☐ No

For what conditions?____________________

Are you taking any new medications?____________ If so, what?____________________

Patient's Signature____________________ Date____________