AUSTIN
ORTHODONTICS

Registration

Patient ID #________________

Welcome to our office! Please assist us in answering the following (complete in ink):

Patient's Name: __________ (last) __________ (first) __________ (middle)

Address: __________ (street) __________ (city) __________ (zip) S.S.# __________

Date of Birth: __________ Sex: M / F __________

Phone: (H) __________ (W) __________

Emergency Contact Person: __________ (name, relationship) Phone: __________

School Attending: __________ Grade: __________ Or Occupation: __________

Hobbies / Interests: __________

Responsible party e-mail: __________

Patient e-mail: __________

If patient is a minor

Mother: __________ Marital Status: S M D W Sep.

Employer/Occupation: __________ S.S.# __________

Father: __________ Marital Status: S M D W Sep.

Employer/Occupation: __________ S.S.# __________

If patient is an adult

Spouse/Other: __________ Phone: (H) __________ (W) __________

Employer/Occupation: __________ S.S.# __________

Who will pay this account? __________

Do you have insurance that may cover any part of orthodontic services? ☐ Yes ☐ No

Name of Employer: __________ Phone: __________

Address: __________

Name of Insurance Company: __________ Phone: __________

ID # __________ Group # __________ Policy Holders Date of Birth: __________

We do not directly accept insurance assignment, but we will assist you in completing and submitting your insurance forms so that you may be reimbursed. Payment is due at the time services are rendered unless prior arrangements have been made.

Patient's Family Physician: __________

City: __________

Ph: __________

Date of most recent physical: __________ Current Height: __________ Weight: __________

Is the patient currently taking any medication? ☐ Yes ☐ No If yes, please list: __________

Is the patient currently being treated for any medical condition? ☐ Yes ☐ No If yes, please describe: __________

Does the patient have or has he/she ever had:

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Anemia	☐	☐	Diabetes	☐	☐
Heart Murmur	☐	☐	Epilepsy	☐	☐	High Blood Press.	☐	☐
Heart Attack/Stroke	☐	☐	Asthma	☐	☐	HIV+/AIDS	☐	☐
Hepatitis	☐	☐	Blood Disorders	☐	☐	Bone Disorders	☐	☐
Tuberculosis	☐	☐	Herpes (any type)	☐	☐	Cancer	☐	☐
Sleep Apnea	☐	☐	Acid Reflux/Ulcer	☐	☐	Severe Headache	☐	☐

Please describe any conditions noted above, or other significant medical history: ____________

Please list any allergies and types of reactions experienced: ____________

Yes No

☐ ☐ Does the patient have difficulty breathing through his/her nose?

☐ ☐ Has the patient had their adenoids or tonsils removed? If yes, at what age? ____________

Children and Adolescents:

Yes No

☐ ☐ Girls- Has monthly cycle started yet? If so, when? ____________

☐ ☐ Boys- Has voice changed yet? If so, when? ____________

Father's Height ____________ Mother's Height ____________

Female Patients:

Yes No

☐ ☐ Are you pregnant? If yes, how far along? ____________

	Yes	No
Name of Family Dentist: ____________ **Did he/she refer you to our office?**	☐	☐
If no, whom may we thank for referring you to our office? ____________		
Date of most recent dental exam: ________ **Is the patient seen by a general dentist every 6 months?**	☐	☐
Please describe why you sought this orthodontic consultation: ____________		
Has the patient previously been seen by another orthodontist, or had any prior orthodontic treatment? If yes, please describe: ____________	☐	☐
Does the patient currently have any dental or jaw pain? If yes, please describe: ____________	☐	☐
Has the patient ever had treatment for periodontal disease (gum disease)? If yes, please describe: ____________	☐	☐
Does the patient use tobacco products?	☐	☐

Does the patient have any of the following habits?

☐ thumb/finger sucking ☐ lip biting/nail biting ☐ grinding/clenching teeth

If the doctor feels that x-rays are indicated during the course of orthodontic examination and treatment, do we have your permission to take them? ☐ ☐

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical status. I understand that Orthodontics is a dental specialty dealing with the alignment of the teeth and jaws, and is different from General Dentistry. I also understand that good oral hygiene and regular visits (at minimum every 6 months) to my Family/General Dentist are critical to maintaining dental health before, during, and after orthodontic treatment.

____
Signature of patient date

____
Signature of guardian if patient is a minor date