

HILLSBORO

ORTHODONTICS

the art of a beautiful smile

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SPECIALIST IN ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS

Registration and Health History (for Adults)

ABOUT YOU

Name: _____ I prefer to be called: _____

Age: _____ Sex: _____ Birthday: _____ Soc. Sec. # _____

Home address: _____
STREET CITY STATE ZIP

Cell phone: _____ Wk phone: _____ Email: _____

Whom may we thank for referring you to this office? _____

Names of other family members treated by our office: _____

Employer: _____ Occupation: _____ # Years _____

Employer's address: _____

Spouse's name: _____

Employer: _____ Occupation: _____ # Years _____

Soc. Sec. # _____ Birthdate: _____ Work Phone: _____

Person responsible for account: Name: _____

(If different from above) Address: _____

Home Phone: _____ Work phone _____

DENTAL INSURANCE

Insured's name: _____ Insured's Soc., Sec. #: _____

Primary Insurance Co: _____ Group #: _____ Local #: _____

Insurance Co address: _____
STREET CITY STATE ZIP

Do you have dual coverage? Yes No

If yes: Insured's name: _____ Insured's Soc. Sec. #: _____

Secondary Insurance Co: _____ Group #: _____ Local #: _____

Insurance Co address: _____

GENERAL INFORMATION

Names and ages of children: _____

Leisure time activities (hobbies) that the patient enjoys: _____

Has any member of the family had orthodontic treatment? Yes No

If so, who? _____

I authorize Hillsboro Orthodontics to furnish information necessary for processing of all charges by my insurance and assign Hillsboro Orthodontics all monies paid by my insurance toward the services performed.

Signature: _____ Date: _____

(please complete other side)

DENTAL HISTORY

Date of last dental check-up (if known): _____

Name and address of your dentist: _____

Have you been treated for periodontal disease? Yes No

Have there been any injuries to the face, mouth, or teeth? Yes No When? _____

Do you grind your teeth? Yes No While asleep During the day

Do you clench your teeth/jaws? Yes No While asleep During the day

Do you suffer from regular headaches, jaw aches (TMJ), or facial pain? Yes No

If yes, when does it hurt? _____

how often does it occur? Daily Weekly Monthly Only on occasion Other _____

have you received treatment for this condition? Yes No

are you still undergoing treatment? Yes No By whom? _____

Have you previously had an orthodontic consultation? Yes No By Whom? _____

Have you previously undergone any orthodontic treatment? Yes No By Whom? _____

If yes, when and by whom? _____

Please give your reasons for having an orthodontic consultation: _____

MEDICAL HISTORY

Date of last physical exam (if known): _____

Name and address of your physician: _____

Do you have or have you had any of the following? (please indicate with a check mark)

Any heart problems

Allergies to anesthetics

Hepatitis

Sinus Problems

High blood pressure

Allergies to medicines/drugs

Herpes

Stroke

Low blood pressure

Allergies to _____

Malignancies

Typhoid fever

Circulatory problems

Nervous problems

Measles

Tonsillitis

Radiation treatments

Anemia

Mumps

Tuberculosis

Excessive bleeding

Arthritis

Psychiatric care

Ulcer

AIDS/HIV positive

Asthma

Rheumatic fever

Venereal disease

Chronic headaches

Diabetes

Scarlet fever

Other

Are you pregnant? Yes No

Please indicate any medication(s) that you are presently taking: _____

Are you allergic to any medications? Yes No List: _____

Do you smoke or chew tobacco? Yes No

Have you ever been hospitalized? Yes No Why/date: _____

Have you ever been seriously ill? Yes No Explain: _____

Have you ever had a blood transfusion? Yes No

Have you been tested for AIDS? Yes No

Are you now under medical doctor care? Yes No Condition: _____

Doctor: _____

Have you ever taken cortisone, steroids, or similar drugs? Yes No When? _____

Have you ever bled excessively from minor cuts, previous surgery, or following a tooth extraction? Yes No

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment: _____