HILLSBORO ORTHODONTICS

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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

Hm 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 phome _____

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 orthdontic 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)

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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 clinch 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: _____