LEE, YOUNG & UBALDO ORTHODONTICS / ADULT REGISTRATION

DATE

Thank you for completing the information below. All information will be kept confidential and will help us provide the best care and service.

PATIENT NAME: ☐ MR. ☐ MRS. ☐ MS. ☐ DR. | TITLE | FIRST | M | LAST | PREFERRED NAME

HOME ADDRESS: | STREET | CITY | STATE | ZIP

PHONE: | HOME | CELL | OFFICE/EXT | EMAIL ADDRESS

HOW WOULD YOU LIKE US TO CONTACT YOU? ☐ PHONE ☐ EMAIL ☐ BOTH

HOW WOULD YOU LIKE TO RECEIVE REMINDERS FOR YOUR APPOINTMENTS? ☐ PHONE ☐ TEXT ☐ EMAIL ☐ ALL

EMPLOYER: | BUSINESS ADDRESS

SOCIAL SECURITY NUMBER | BIRTH DATE (MONTH/DAY/YEAR) | ☐ MALE ☐ FEMALE ☐ PREFER NOT TO IDENTIFY

MARRIED ☐ YES ☐ NO | SPOUSE'S NAME

SPOUSE'S EMPLOYER | BUSINESS ADDRESS | PHONE | EMAIL ADDRESS

WHO WILL BE RESPONSIBLE FOR THIS ACCOUNT? ☐ SELF ☐ OTHER | BILLING NAME (IF DIFFERENT) | BILLING ADDRESS

DO YOU HAVE ORTHODONTIC INSURANCE COVERAGE? ☐ YES ☐ NO ☐ UNSURE *IF YES PLEASE COMPLETE INSURANCE INFORMATION FORM.* IF DUAL COVERAGE, PLEASE COMPLETE BOTH PRIMARY AND SECONDARY CARRIER SECTIONS.

CLOSEST RELATIVE NOT LIVING WITH YOU? | RELATIONSHIP | NAME | ADDRESS | PHONE

WHOM MAY WE THANK FOR REFERRING YOU?

ARE WE TREATING ANY OF YOUR FRIENDS/FAMILY MEMBER? ☐ YES ☐ NO IF YES, NAME? _____

MEDICAL HISTORY

PHYSICIAN NAME | DATE OF LAST VISIT

ADDRESS | STREET | PHONE

CITY | STATE | ZIP

DENTAL HISTORY

DENTIST'S NAME | DATE OF LAST VISIT

ADDRESS | STREET | PHONE

CITY | STATE | ZIP

YES NO

- ☐ ☐ HAVE YOU UNDERGONE A COMPLETE PHYSICAL EXAM IN THE PAST YEAR?
- ☐ ☐ ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE?
- ☐ ☐ HAVE YOU HAD MAJOR SURGERY?
- ☐ ☐ HAVE YOU EVER BEEN HOSPITALIZED?
- ☐ ☐ ARE YOU TAKING ANY DRUGS OR MEDICATIONS?
- ☐ ☐ ARE YOU ALLERGIC TO ANY MEDICATION?
- ☐ ☐ HAVE YOU HAD ANY UNUSUAL REACTION TO ANY MEDICATION?
- ☐ ☐ HAS PATIENT TAKEN ANY DIET MEDICATION (IE: FEN FEN)?
- ☐ ☐ HAS PATIENT TAKEN BISPHOSPHONATES? (IE: FOSAMAX, ACTONEL, OR ZOMETA)
- ☐ ☐ DO YOU EVER HAVE FAINTING OR DIZZY SPELLS?
- ☐ ☐ DO YOU HAVE HIGH OR LOW BLOOD PRESSURE?
- ☐ ☐ ARE YOU PREGNANT?
- ☐ ☐ DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

☐ HEART PROBLEMS	☐ HEPATITIS
☐ KIDNEY PROBLEMS	☐ RHEUMATIC FEVER
☐ LUNG PROBLEMS	☐ NERVOUS PROBLEMS
☐ LIVER PROBLEMS	☐ PSYCHIATRIC CARE
☐ ALLERGIES	☐ MALIGNANCIES
☐ DIABETES	☐ ENDOCRINE PROBLEMS
☐ EPILEPSY	☐ BONE DISORDERS
☐ ARTHRITIS	☐ PROLONGED BLEEDING
☐ ANEMIA	☐ ASTHMA
☐ TUBERCULOSIS	☐ IMPLANTS

ARE THERE ANY OTHER MEDICAL PROBLEMS WE SHOULD BE AWARE OF?

ADDITIONAL INFORMATION OR COMMENTS: _____

WHAT BOTHERS YOU MOST ABOUT YOUR TEETH? _____

WHAT DO YOU EXPECT FROM ORTHODONTIC TREATMENT?

YES NO

- ☐ ☐ HAVE YOU HAD PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT?
- ☐ ☐ DO YOU HAVE DIFFICULTY CHEWING OR SWALLOWING FOOD?
- ☐ ☐ ARE YOU AWARE OF TOOTH GRINDING OR CLENCHING?
- ☐ ☐ DO YOU HAVE A HEADACHE MORE THAN ONCE A WEEK?
- ☐ ☐ HAVE YOU EVER HAD PAINS IN THE FACE OR HEAD?
- ☐ ☐ ARE YOU BOTHERED BY CHRONIC NECK PAINS?
- ☐ ☐ HAVE YOU EVER HAD A SEVERE FACE OR JAW INJURY?
- ☐ ☐ DO YOU HAVE ANY PAIN OR CLICKING OF YOUR JAW JOINTS?
- ☐ ☐ DO YOU HAVE CHRONIC SORES INSIDE YOUR MOUTH?
- ☐ ☐ HAVE YOU HAD ANY PERMANENT TEETH EXTRACTED?
- ☐ ☐ DO YOUR GUMS BLEED ON BRUSHING OR FLOSSING? HOW MANY TIMES A WEEK DO YOU USE DENTAL FLOSS? _____
- ☐ ☐ HAVE YOU EVER BEEN TREATED FOR GUM DISEASE?
- ☐ ☐ HAVE YOU HAD ANY PREVIOUS UNPLEASANT DENTAL OR ORTHODONTIC EXPERIENCES?
- ☐ ☐ ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS WE SHOULD BE AWARE OF? _____

YOUR SIGNATURE: _____ DATE: _____