



Grubaugh Orthodontics

Grubaugh Orthodontics Patient Registration and Health/Dental History- Adult
Welcome to our office. Please fill out both pages of this form. All information is CONFIDENTIAL.

Patient Information PAGE 1 of 2

Patient's Name: _____ Birth Date: _____ Age: _____ Sex: F M
 Prefers to be called: _____ Cell #: _____ Home #: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____ Hobbies: _____
 Occupation and Employer: _____ Work #: _____

Whom may we thank for referring you?: _____
 Other family members who are patients of our office:

Family Information

Children in the Family (List Name(s) and Date of Birth):

Marital Status: Married Divorced Separated Single Widowed

Spouse's name: _____ Cell # _____
 Occupation and Employer: _____

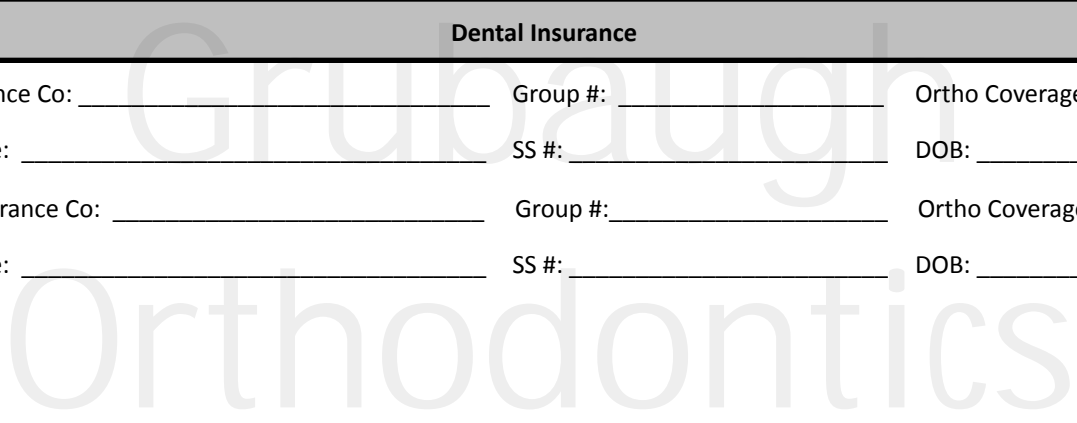
Responsible for the account: Self Spouse Other:

Contact in Case of Emergency

Name: _____ Home #: _____ Cell #: _____

Dental Insurance

Primary Insurance Co: _____ Group #: _____ Ortho Coverage Y N
 Insured's Name: _____ SS #: _____ DOB: _____
 Secondary Insurance Co: _____ Group #: _____ Ortho Coverage Y N
 Insured's Name: _____ SS #: _____ DOB: _____
 Other: _____



Patient's Dentist: _____ Last Dental Exam/Cleaning Date: _____

What is your main orthodontic concern? _____

What aspect(s) of orthodontic treatment are you most concerned with? Quality Cost Time Discomfort

Have you had a previous orthodontic consult? Date: _____ Orthodontist name: _____

Other family members have had orthodontic treatment? Satisfied with the results? Y N
 Spouse (Dr _____) Children (Dr _____) Other Family Members (Dr _____)

Antibiotic premedication is needed before dental procedures? **Antibiotic and dosage taken:** _____

Oral Habits (thumb/finger sucking, lip/nail biting)? **Explain:** _____

Problems with Teeth or Gums?	Speech Problems/Therapy?	Difficulty Opening Jaw?
Grind or Clench Teeth?	Pain, Tenderness in Jaw?	Mouth Breathing or Snoring?
Any Missing or Extra Permanent Teeth?	Popping, Noises in Jaw?	Tongue Thrusting or Functional Problem?
Injury to Face, Teeth, or Mouth? Explain: _____		Other Dental Info: _____

Medical Information

Name of Family Physician: _____ Last Physical Exam: _____ Weight: _____ Height: _____

Any Hospitalizations or Surgeries? **Explain:** _____

Under the care of a physician for an illness? **Explain:** _____

Current medications (including non-prescription), supplements, or herbs? **List all and reason for taking:** _____

Check the boxes if you have or ever had any of the following?

Females: Pregnant or considering pregnancy in the next 2 years? Currently Nursing?
 Currently taking oral contraceptives?

Have Allergies:	Local Anesthetic	Aspirin	Ibuprofen	Penicillin/Amoxicillin	Sulfa drugs	Codeine	Metal	Latex
	Food (specify) _____			Other (specify) _____				

ADD/ADHD	Bone Disorders/Bone Loss	Heart Disease/Heart Attack/Stroke	Stomach/Bowel Problems
Autism	Cancer/Chemotherapy/Radiation	Chew or Smoke Tobacco	Low Blood Pressure/Fainting
Autoimmune Disorders	Diabetes/Endocrine Problems	High Blood Pressure	Substance Abuse
Artificial Valves or Joints	Eating Disorder	Headaches/Migraines	Rheumatic Fever/Endocarditis
Arthritis	Emotional Problems/Depression	Herpes (Cold Sores)	Tonsils/Adenoids Removed
Asthma/Breathing Difficulties	Epilepsy/Seizures	Hepatitis/Liver Problems	Thyroid Problems
Birth/Congenital Defects	Handicaps/Disabilities	HIV/AIDS Positive	Tuberculosis
Blood/Bleeding Disorders	Heart Defect/Murmur/Valve Prolapse	Kidney Disease	STDs

Taken bisphosphonates such as Zometa, Aredia, Didorenal, Fosamax, Actonel, Boniva, Skelid or Didronel, etc. for bone disorders, osteoporosis or cancer?

Other medical information (attach additional sheets if necessary):

I certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE OR UNDISCLOSED INFORMATION. I understand that it is my responsibility to inform this office of any changes to the patient's medical/dental status. I grant authority to the doctor and staff to perform all procedures and treatment in the patient's best interest. I authorize the orthodontist to share pertinent treatment information with collaborating dentists and specialists. I authorize the billing of insurance for treatment procedures when appropriate.

Signature of Patient

Date

Signature of Orthodontist

Date