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

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**