Adult Registration Form

Dubin Orthodontics
Established 1976

Patient's Name: _____ Nickname: _____ Social Security #: _____

Birthdate: _____ ❑ Male ❑ Female ❑ Other Cell phone: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

Employer: _____ Current Position: _____

Patient's Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Whom may we thank for this referral:Dentist/Friend/Other(name): _____

Family member who have been patients (name/relationship): _____

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Spouse's name (if married): _____

PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM ABOVE)

Name: _____ Relationship: _____ Social Security #: _____

Address (if different from above): _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Employer: _____ Current Position: _____

PRIMARY DENTAL INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Policy or SS#: _____ Grp#: _____

Insured's Name: _____ Insured's Birthdate: _____

Relationship to Patient: _____

Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone: _____

Policy or SS#: _____ Grp#: _____

Insured's Name: _____ Insured's Birthdate: _____

Relationship to Patient: _____

Insured's Employer: _____

MEDICAL HISTORY

	Please Circle			Please Circle			Please Circle	
Heart Murmur/Congenital Defect	Y	N	High Blood Pressure	Y	N	Latex Allergy	Y	N
Heart Problems	Y	N	Convulsions/Epilepsy	Y	N	Asthma	Y	N
Diabetes	Y	N	HIV/AIDS	Y	N	Hearing Impairment	Y	N
Rheumatic Fever	Y	N	Hemophilia	Y	N	Learning Disability	Y	N
Cancer	Y	N	Kidney/Liver Problems	Y	N	Special Needs	Y	N
Blood Transfusions	Y	N	Hepatitis	Y	N	Autism	Y	N
Operations/Stays in Hospital	Y	N	Sinus Problems	Y	N	ADD	Y	N
Fainting	Y	N	Headaches/Migraines	Y	N	ADHD	Y	N
Tuberculosis	Y	N	Allergies to Drugs	Y	N	Medications	Y	N
Osteoporosis/Bone condition	Y	N	Pregnant	Y	N	Prolonged use of NSAIDs (Advil, Mortin, Aleve,etc)	Y	N

If you have circles **Yes** for any of the above, please explain: _____

_____

DENTAL HISTORY

	Please Circle			Please Circle			Please Circle	
Unfavorable Dental Experience	Y	N	Missing Teeth	Y	N	Mouth Breathing	Y	N
Injuries to Face/Teeth	Y	N	Extra Teeth	Y	N	Other Orthodontic Txt	Y	N
Pain/Noises in the Jaw Joint (TMJ)	Y	N	Speech Problems	Y	N	Finger Sucking	Y	N
Root Resorption	Y	N	Gums Bleed	Y	N	Tongue Thrusting	Y	N
Periodontal Disease	Y	N	Grind Teeth	Y	N	Nail Biting	Y	N
Antibiotics Prior to Dental Txt	Y	N	Canker/Cold sores	Y	N	Chipped Teeth	Y	N
Chewing/Eating issues	Y	N	Cleft Lip/Palate	Y	N			

If you have circles **Yes** for any of the above, please explain: _____

_____

What is your main concern: _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

✓_____ Signature

✓_____ Date

We appreciate your efforts in fully completing this registration form. It assists our office in providing the best care possible.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Member American Association of Orthodontists®