

Welcome to the orthodontic office of
Dr. Marie Doulaverakis

Date: _____

PATIENT REGISTRATION

NAME _____ NICKNAME _____ SEX _____ AGE _____
ADDRESS _____ CITY/STATE _____ ZIP _____
SSN _____ BIRTHDATE _____ HOME PHONE _____ CELL _____
***Best Phone Number to Reconfirm Appointments on: _____ Email Address: _____

School: _____ Hobbies/Sports _____
(This determines if we give the patient a mouth guard to protect his/her braces.)

SIBLINGS NAMES AND AGE _____

NAME and ADDRESS OF DENTIST _____

DENTIST PHONE _____ DENTIST FAX _____ DATE OF LAST VISIT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

DO YOU KNOW ANY PATIENTS IN OUR PRACTICE? IF SO, WHO? _____

PLEASE CHECK REASONS FOR SEEKING AN ORTHODONTIC CONSULTATION:

- SUGGESTED BY DENTIST CROWDING SPACING BAD BITE OVERBITE
 UNDER BITE EXCESSIVE WEAR/GRINDING HABITS GUMMY SMILE
 OTHER

RESPONSIBLE PARTY INFORMATION

NAME _____ RELATIONSHIP TO PATIENT _____ MARITAL STATUS _____
ADDRESS _____ CITY/STATE _____ ZIP _____
HOW LONG AT THIS ADDRESS _____ WORK PHONE _____ HOME _____ CELL _____
SSN _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

SPOUSE'S NAME _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____
SSN _____ WORK PHONE _____ HOME _____ CELL _____
EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED _____

DENTAL INSURANCE INFORMATION

INSURED'S NAME _____ INSURED'S SSN _____
INSURANCE CO _____ GROUP# _____ INSURANCE PHONE _____
INSURED ADDRESS _____
PATIENT'S RELATIONSHIP TO INSURED _____
EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____
INSURANCE CO ADDRESS _____ EFFECTIVE DATE _____

DO YOU HAVE DUAL COVERAGE? YES NO **IF YES: PLEASE COMPLETE BELOW**
INSURED'S NAME _____ INSURED'S SSN _____
INSURANCE CO _____ GROUP# _____ INSURANCE PHONE _____
INSURED ADDRESS _____
PATIENT'S RELATIONSHIP TO INSURED _____
EMPLOYER NAME _____ EMPLOYER PHONE NUMBER _____
INSURANCE CO ADDRESS _____ EFFECTIVE DATE _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ CITY _____ LAST SEEN _____

- YES NO**
- IS PATIENT EXPERIENCING ANY HEALTH PROBLEMS? PLEASE EXPLAIN _____
 - DOES PATIENT HAVE HISTORY OF MAJOR ILLNESS? PLEASE EXPLAIN _____
 - HAS PATIENT EVER BEEN ADMITTED FOR HOSPITAL? FOR WHAT REASON _____
 - IS PATIENT TAKING ANY MEDICATIONS OR DRUGS? PLEASE LIST _____
 - IS PATIENT ALLERGIC TO ANY MEDICATIONS OR DRUGS? PLEASE LIST _____
 - HAS PATIENT'S TONSILS OR ADENOIDS BEEN REMOVED? WHAT AGE? _____

PLEASE CIRCLE ANY OF THESE FOLLOWING IF PATIENT HAS BEEN DIAGNOSED WITH:

- | | | | |
|--------------------------------|------------------------------------|------------------------------|-------------------------------------|
| YES NO AIDS/HIV | YES NO Cortisone Treatments | YES NO Jaw Pain | YES NO Skin Rash |
| YES NO Anemia | YES NO Cough, persistent or bloody | YES NO Kidney Disease | YES NO Special Diet |
| YES NO Arthritis, Rheumatism | YES NO Diabetes | YES NO Liver Disease | YES NO Stroke |
| YES NO Artificial Heart Valves | YES NO Emphysema | YES NO Low Blood Pressure | YES NO Swollen Feet or Ankles |
| YES NO Artificial Joints | YES NO Epilepsy | YES NO Mitral Valve Prolapse | YES NO Swollen Neck Glands |
| YES NO Asthma | YES NO Fainting or dizziness | YES NO Nervous Problems | YES NO Thyroid Problems |
| YES NO Back Problems | YES NO Glaucoma | YES NO Pace Maker | YES NO Tonsillitis |
| YES NO Bleeding, prolonged | YES NO Headaches or Migraines | YES NO Psychiatric Care | YES NO Tuberculosis |
| YES NO Blood Disease | YES NO Head or Neck Pain | YES NO Radiation Treatment | YES NO Tumor/growth on head or neck |
| YES NO Cancer | YES NO Heart Problems | YES NO Respiratory Disease | YES NO Ulcer |
| YES NO Chemical Dependency | YES NO Hepatitis Type _____ | YES NO Rheumatic Fever | YES NO Weight Loss, unexplained |
| YES NO Chemotherapy | YES NO Herpes | YES NO Scarlet Fever | YES NO Sinus Trouble |
| YES NO Circulatory Problems | YES NO High Blood Pressure | YES NO Shortness of Breath | YES NO Jaundice |

OTHER CONDITIONS NOT MENTIONED _____

NEAREST RELATIVE IN CASE OF EMERGENCY _____ PHONE _____ RELATIONSHIP _____

DENTAL HISTORY

- YES NO**
- STARTED TEETHING VERY EARLY OR LATE?
 - PRIMARY (BABY) TEETH REMOVED THAT WERE NOT LOOSE?
 - HAS PATIENT HAD ANY UNPLEASANT EXPERIENCE IN A DENTAL OFFICE?
 - PREVIOUS INJURIES TO FACE, MOUTH, OR TEETH?
 - THUMB OR FINGER SUCKING HABIT? IF SO, UNTIL WHAT AGE? _____
 - HISTORY OF SPEECH PROBLEMS?
 - ABNORMAL SWALLOWING HABIT OR TONGUE THRUSTING?
 - MOUTH BREATHING HABIT OR DIFFICULTY BREATHING?
 - MISSING OR EXTRA PERMANENT TEETH?
 - PERIODONATAL (GUM) PROBLEMS OR BONE LOSS?
 - ANY TEETH IRRITATING CHEEK, LIP, OR TONGUE
 - CLICKING OR POPPING OF THE JAW?
 - DIFFICULTY IN OPENING, CLOSING, OR CHEWING?
 - PAIN OR SORENESS IN MUSCLES OF FACE OR AROUND THE EARS?
 - CLENCHING OR GRINDING OF THE TEETH WHILE AWAKE OR ASLEEP?
 - IS PATENT CONCERNED ABOUT APPEARANCE OF TEETH?
 - WOULD YOU MIND WEARING BRACES IF NEEDED?
 - HAVE YOU HAD ANY PREVIOUS ORTHODONTIC TREATMENT?
 - HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY?
WHO? _____ WHERE ? _____ DATE _____
 - HAVE ANY FAMILY MEMBERS HAD ORTHODONTIC TREATMENT? WHO? _____
 - ANY OTHER INFORMATION THAT MAY BE HELPFUL _____

I understand that where appropriate, credit bureau reports may be obtained. If there are any changes to this history record of medical/dental status, I will so inform this practice.

Parent/Guardian Signature _____ Date _____

OFFICE USE:

DATE	INITIALS	CHANGES	UPDATE
		YES / NO	
		YES / NO	
		YES / NO	
		YES / NO	