PATIENT REGISTRATION
WILSON ORTHODONTICS
(please print)

Date_____ **Patient e-mail address**_____

Patient's First Name_____Middle Initial____Last Name_____Home Phone #_____

Cell Phone #_____

Patient's Address_____City_____State_____Zip_____

Sex_____ Miss/Mrs/Ms/Mr. (circle one) Age_____Birthdate_____

Patient's Employer_____ Length of Employment There_____

Patient's Business Phone_____

Spouse's Name_____

Spouse's Address (if different from pt.)_____ Phone_____

City_____ State_____ Zip_____

Spouse's Employer_____Length of Employment_____

Spouse's Business Phone_____

Marital Status: (circle one) Married Single Separated Widowed Divorced

Name of Person Responsible for Account_____ Relationship to Patient_____

Patient's Dental Insurance Company_____Group #_____

Spouse's Dental Insurance Company_____ Group #_____

Which of these is the primary dental carrier?_____

Patient's Dentist_____ **Patient's** Physician_____

Were you referred to our office by another patient? Name:_____

Please understand that we may have to have you miss work on occasion for appointments which require more time.

Do we have your permission to share any information, including financial, with your spouse? Yes____ No____

I hereby acknowledge that I have read and understand this form and that all the information I have given above is accurate to the best of my knowledge.

Signed_____ **PLEASE COMPLETE HEALTH HISTORY ON THE BACK OF THIS FORM**

ALLERGIES:

Hay fever?	Yes	No
Dental material?	Yes	No
Latex?	Yes	No
Drugs?	Yes	No

Please list_____

SERIOUS ILLNESSES:

Diabetes?	Yes	No
Epilepsy?	Yes	No
Polio?	Yes	No
Tuberculosis? (TB)	Yes	No
Rheumatic Fever?	Yes	No
Heart damage?	Yes	No
Heart murmur?	Yes	No
Hemophilia	Yes	No
Radiation treatment?	Yes	No
Hearing difficulty?	Yes	No
Recurrent earaches?	Yes	No
Thyroid condition?	Yes	No
Recurrent sore throat?	Yes	No
AIDS or HIV?	Yes	No
Hepatitis?	Yes	No
Birth defects?	Yes	No

Other illnesses_____

_____

SERIOUS INJURIES:

Ever had head injury?	Yes	No
Face injury?	Yes	No
Tooth injury?	Yes	No

Brief description of injury_____

_____

OPERATIONS/HOSPITALIZATIONS:

Tonsils removed?	Yes	No
Adenoids removed?	Yes	No
Blood transfusions?	Yes	No

Other:_____

MUSICAL INSTRUMENT:_____

SPORTS:_____

FEMALE PATIENTS ONLY:

Is it possible that you could be pregnant?	Yes	No
BREATHING DIFFICULTIES?	Yes	No

Explain_____

SPEECH:

Speech problems?	Yes	No
Speech therapy?	Yes	No

Explain_____

_____

GAGGING PROBLEM: Yes No

DENTAL HEALTH:

Date of last dental visit:_____

Jaw noises? (clicking/etc.)	Yes	No
Jaw/face pain?	Yes	No
TMJ problems?	Yes	No
Bleeding gums?	Yes	No
Any fillings?	Yes	No

ORAL HABITS:

Thumb/finger sucking habit?	Yes	No
Is this a current habit?	Yes	No
Grinding of teeth?	Yes	No
Chewing difficulties?	Yes	No

Joint replacement/Prosthetic Implant? Yes No

Are you currently taking any medications? Yes No Please list medications_____

_____

Are you currently under a doctor's care? Yes No If yes, please explain_____

_____

Have you had previous orthodontic treatment? Yes No

Do you have any disease not listed above? Yes No If yes, please explain_____

_____

Do you require premedication for heart murmur? Yes No

I HAVE READ AND UNDERSTAND THIS MEDICAL HISTORY. I WILL NOT HOLD THE OFFICE OF TIMOTHY G. WILSON RESPONSIBLE FOR ANY OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM AND, IF THERE ARE ANY CHANGES TO THIS MEDICAL HISTORY, I WILL NOTIFY THE OFFICE AS SOON AS I AM AWARE OF THEM.

SIGNED_____**DATE**_____**DR.**_____