**HUB CITY ORTHODONTICS**

**PATIENT REGISTRATION**

**(PLEASE PRINT) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PATIENT

Patient's Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name/Initial: \_\_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_\_ Age: \_\_\_\_\_\_ Identifies as Male/Female/\_\_\_\_\_\_\_ Prefers to be Called: \_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone No.: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Number of Siblings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Family Members Treated Here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who Referred You To Our Office? Dentist / Friend \_\_\_\_\_\_\_\_\_\_\_\_/ Family \_\_\_\_\_\_\_\_\_\_\_\_ / Internet / Other \_\_\_\_\_\_\_\_\_

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

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPOUSE/PARTNER

**Spouse/Partner**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone No. (if different than patient's): (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_

Address (if different than patient's): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTIST/PHYSICIAN

**Name Of Patient's Dentist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: (\_\_\_ ) \_\_\_\_-\_\_\_\_\_

Date Last Seen: \_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name Of Patient's Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.: (\_\_\_ ) \_\_\_\_-\_\_\_\_\_

FINANCIAL

**Who Is Financially Responsible For This Account**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_

Insurance Coverage For Orthodontic Treatment? Yes No Unsure

**Primary Policy Holder's Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Policy Holder's Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID: \_\_\_\_\_\_\_\_\_\_\_\_\_

For the following questions mark YES or NO. The answers are for office records only and will be consider confidential.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT PROFILE** | | |  | **ALLERGIES** | | |
| Yes | No | Do you brush your teeth consistently?  How often do you brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes  Yes | No  No | Dental material  Local Anesthetics |
| Yes | No | Are there any learning concerns or need for extra help with instructions? | Yes  Yes | No  No | Latex  Vinyl/Acrylic |
| Yes | No | Are you self-conscious about your teeth?  If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes | No | Medications  If yes list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| **MEDICAL HISTORY (PAST OR PRESENT)** | | | **OPERATIONS/HOSPITALIZATIONS** | | |
| Yes | No | Birth defects or hereditary diagnoses | Yes | No | Tonsils removed |
| Yes | No | Bone fractures, any major incidents | Yes | No | Adenoids removed |
| Yes | No | Endocrine or thyroid diagnoses | Yes | No | Blood transfusions |
| Yes | No | Diabetes | Yes | No | Joint replacement/prosthetic implant |
| Yes | No | Autism Spectrum Disorder |  |  |  |
| Yes | No | Cancer, tumor, radiation, or chemotherapy | **GROWTH AND DEVELOPMENT** | | |
| Yes | No | Stomach ulcer or hyperacidity | Yes | No | Abnormal growth pattern |
| Yes | No | Polio, mononucleosis, tuberculosis, or pneumonia | Yes | No | Recent rapid growth |
| Yes | No | Skin Disorder | Yes | No | Any signs of puberty |
| Yes | No | Fainting, seizures, epilepsy, neurologic problems |  | | |
| Yes | No | AIDS or HIV positive | **FEMALE PATIENTS ONLY** | | |
| Yes | No | Hepatitis, jaundice, or liver problem | Yes | No | Started menstruation |
| Yes | No | Problems of the immune system |  |  | If yes, approximate date: \_\_\_\_\_\_\_\_\_ |
| Yes | No | Mental health or behavioral concerns | Yes | No | Pregnant |
| Yes | No | Vision, hearing, tasting or speech difficulties |  | | |
| Yes | No | Loss of weight recently, poor appetite | **DENTAL HISTORY (PAST OR PRESENT)** | | |
| Yes | No | History of eating disorder (anorexia, bulimia) | Yes | No | History of dental trauma |
| Yes | No | Excessive bleeding or bruising tendency, anemia, or bleeding disorder | Yes  Yes | No  No | Jaw fractures or cysts  Bleeding gums |
| Yes | No | High or low blood pressure | Yes | No | Tooth grinding/clenching |
| Yes | No | Rheumatic fever | Yes | No | Joint noises (clicking/pop) |
| Yes | No | Chest pain, shortness of breath or swelling ankles | Yes | No | Jaw/face pain |
| Yes | No | Hemophilia | Yes | No | Sensitive teeth |
| Yes | No | Heart Murmur | Yes | No | Thumb/finger/sucking habit |
| Yes | No | Breathing difficulty |  |  | If yes, until what age? \_\_\_\_\_\_\_\_\_ |
| Yes | No | Hayfever, asthma, sinus trouble or hives | Yes | No | Chewing difficulties |
| Yes | No | Frequent headaches, colds, or sore throats | Yes | No | Congenitally missing adult teeth |
| Yes | No | Eye, ear, nose or throat condition | Yes | No | Previous orthodontic treatment |
|  |  |  |  |  |  |
| **MEDICATIONS** | | | **OTHER HEALTHCARE PROFESSIONAL** | | |
| Yes | No | Do you require premedication? | Yes | No | Are you currently under the care of |
| Yes | No | Are you currently taking any medications? |  |  | another healthcare professional? |
|  |  | If yes please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Name of Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Do we have permission to share any information, including financial with another individual? Yes No**

**If yes please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I have read and understand the above questions. I will not hold my orthodontist or any member of his/her team responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status. I will notify Hub City Orthodontics.**

Patient Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor (signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_