**Patient's Preferred Name**_________________________________DOB_________________Age_____

**ORTHODONTIC HISTORY**

**Have you consulted an orthodontist previously? No ☐ Yes ☐**

**Have you had prior orthodontic treatment? No ☐ Yes ☐**

**What motivated you to seek orthodontic care?** ______________________________________________

**What are your expectations from orthodontic treatment?** ____________________________________

______________________________________________________________________

**How do you feel about wearing braces?** _____________________________________________

**Have any of your friends or members of your family received orthodontic services at our office? Y N**

| Name | Relationship | Name | Relationship |
|---|---|---|---|
| | | | |
| | | | |

**MEDICAL HISTORY**

Physician's Name ___________________________

Are you in good health? **Y / N**

**Check any of the following for which you are now being or have been treated:**

- a. Rheumatic fever ☐
- b. Congenital heart problems ☐
- c. Heart murmurs or heart surgeries ☐
- d. Artificial joints ☐
- e. Any condition that requires prophylaxis (antibiotics) before dental procedures ☐
- f. Cardiovascular disease (heart trouble, heart attack, high blood pressure, stroke) ☐
- g. Hepatitis ☐
- h. Hemophilia ☐
- i. Diabetes ☐
- j. Epilepsy / Convulsions ☐
- k. Asthma ☐
- l. AIDS or HIV positive ☐
- m. Tuberculosis ☐

* Women - Are you pregnant? **Y / N**

**DENTAL HISTORY**

General Dentist ___________________________

Date of last check-up and cleaning _______________

**Check if you have had any of the following treatment:**

1. Periodontal treatment (gum treatment) ☐
   How long ago ___________________________
   Describe the treatment ___________________________
2. Mouthguard or bite splint ☐
3. Surgery to change the bite ☐

**Are you aware of any of the following conditions?**

1. Sores, lumps or irritated areas in mouth ☐
2. Food catching between teeth ☐
3. Clenching or grinding of teeth ☐
4. Sore or bleeding gums ☐
5. Clicking, popping or grating noise in jaw joint ☐
6. Numbness or tingling in mouth or face ☐

Have you had tonsils / adenoids removed? **Y / N**

Have you ever been a thumb sucker? **Y / N** Mouth breather **Y / N**

Have you been asked to Pre-med for dental appointments? **Y / N**

Have you had an unpleasant experience at a dental office? **Y / N**

If yes, explain:___________________________

List any other serious recurrent illness (physical or mental) ______________________________

Prescription medications being taken ______________________________

Do you have a Latex Allergy/Sensitivity? **Y / N**

Drug allergies/sensitivity______________________________

Are you allergic/intolerant to metals? **Y / N** If yes explain______________________________

**The information I have given is correct and will be held in the strictest of confidence.**

**Signature of Patient** ______________________________ **Date** ____________________

**Updated**____________ ____________ ____________ ____________

**Initials/Date** **Initials/Date** **Initials/Date** **Initials/Date**

***Welcome to our office!***

# ADULT REGISTRATION FORM

Eagle River Orthodontics
16635 Centerfield Dr, Suite 201
Eagle River, AK 99577

(Please Print)

| | | | |
|---|---|---|---|
| Today's date: | | General Dentist: | |
| Whom may we thank for referring you to our office? | | | |

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| Last name: | First: | Middle: | Sex: M F | |
| Drivers License #: | SSN: | E-Mail Address: | | |
| Home phone: | Cell: | Birth date: | Age: | |
| Mailing Address: | City: | State: | Zip: | |
| Physical Address: | City: | State: | Zip: | |
| Occupation: | Employer: | Work Phone: | | |

## PATIENT'S SIGNIFICANT OTHER

| | | | |
|---|---|---|---|
| Last Name: | First: | Middle: | |
| SSN: | Birth Date: | Home Phone: | Cell: |
| Occupation: | Employer: | Work Phone: | Drivers License#: |

## ORTHODONTIC INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Policy Holder Name: | Employer of Policy Holder: | | |
| Primary Insurance Company: | | | |
| Primary Insurance Company Address: | | | |
| City: | State: | Zip: | Phone #: |
| Insurance ID: | Group #: | Policy #: | |
| Policy Holder Name: | Employer of Policy Holder: | | |
| Secondary Insurance Company: | | | |
| Secondary Insurance Company Address: | | | |
| City: | State: | Zip: | Phone #: |
| Insurance ID: | Group #: | Policy #: | |

## IN CASE OF EMERGENCY

| | |
|---|---|
| Name of local friend or relative (not living at same address): | |
| Relationship: | Contact #: (     ) |

I hereby authorize the release of any information to my insurance company or companies including records of examinations, diagnosis, or treatment. This release is solely for the purpose or facilitating the billing and reimbursement, directly to Eagle River Orthodontics, of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered.

Date:___________________________________ Patient Signature:___________________________________