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CHILD REGISTRATION

PATIENT'S NAME	NICKNAME	<input type="checkbox"/> Male <input type="checkbox"/> Female	SOC. SEC. #
STREET ADDRESS		BIRTHDATE	
CITY	STATE	ZIP	
SCHOOL	GRADE	HOME PHONE	

RESPONSIBLE PARTY INFORMATION

FATHER'S NAME		BIRTHDATE	SOC. SEC. #
STREET ADDRESS		EMAIL	
CITY		STATE	ZIP
FATHER EMPLOYED BY		HOW LONG?	
EMPLOYER'S ADDRESS		OCCUPATION	
MOTHER'S NAME		BIRTHDATE	SOC. SEC. #
STREET ADDRESS		EMAIL	
CITY		STATE	ZIP
MOTHER EMPLOYED BY		HOW LONG?	
EMPLOYER'S ADDRESS		OCCUPATION	

ADULT REGISTRATION

PATIENT NAME	NICKNAME	SOC. SEC#
STREET ADDRESS		BIRTHDATE
CITY	STATE	ZIP
HOME PHONE	BUSINESS PHONE	MARITAL STATUS
CELL PHONE	EMAIL	
PATIENT'S EMPLOYER		OCCUPATION
EMPLOYER ADDRESS		
SPOUSE'S NAME	BIRTHDATE	SOC. SEC.#
SPOUSE EMPLOYED BY		BUSINESS PHONE

DENTAL AND ORTHODONTIC INSURANCE INFORMATION

PATIENT NAME	RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
EMPLOYEE (SUBSCRIBER NAME)	SOC. SEC. #
INSURANCE CO. NAME	BIRTHDATE
INSURANCE CO. ADDRESS	GROUP NO.
DO YOU HAVE A SECONDARY CARRIER? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES,	
EMPLOYEE (SUBSCRIBER NAME)	SOC. SEC. #
INSURANCE CO. NAME	BIRTHDATE
INSURANCE CO. ADDRESS	GROUP NO.

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle YES or NO (If YES, please fill in details)

YES NO Are you taking any medications? _____

YES NO Are you taking any medications for osteoporosis (example - Fosamax or Actonel)? _____

YES NO Are you allergic to any medication? _____

YES NO Do you have a history of a major illness? _____

YES NO Have you had any operations? _____

YES NO Have you ever been involved in a serious injury? _____

YES NO Have you seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have:

- | | | | |
|------------------------------|---------------------------|---------------------|------------------------|
| Abnormal Bleeding/Hemophilia | Diabetes | Herpes | Prolonged Bleeding |
| Anemia | Dizziness | High Blood Pressure | Radiation/Chemotherapy |
| Arthritis | Epilepsy | HIV/Aids | Rheumatic Fever |
| Asthma or Hayfever | Gastrointestinal Disorder | Kidney Problems | Thyroid Problems |
| Back & Neck Pain | Heart Problems | Nervous Disorders | Tuberculosis |
| Cold Sores/Fever Blisters | Heart Murmur | Osteoporosis | Tumor or Cancer |
| Congenital Heart Defect | Hepatitis/Liver Problems | Pneumonia | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Date of last visit _____

Address _____ City _____ State _____

What concerns you most about your teeth? _____

Whom may we thank for referring you to this office? _____

YES NO Are you presently in dental pain? _____

YES NO Have you ever experienced unfavorable reaction to dentistry? _____

YES NO Have you ever lost or chipped any teeth? _____

YES NO Have there been any injuries to face, mouth, or teeth? _____

YES NO Is any part of your mouth sensitive to temperature? Where? _____

YES NO Is any part of your mouth sensitive to pressure? Where? _____

YES NO Do your gums bleed when you brush? _____

YES NO Do you have any type of thumb or tongue habit? _____ Age when stopped: _____

YES NO Are you a mouth breather? _____

YES NO Have you ever seen an orthodontist? If yes, who and when? _____

YES NO What is your attitude toward receiving orthodontic treatment? _____

YES NO Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

YES NO Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

YES NO Are you aware of your jaw clicking or popping? _____

YES NO Are you aware of clenching your teeth during the day? _____

YES NO Have you ever been told that you grind your teeth? _____

YES NO Do you have "tension" headaches? _____

YES NO Have you ever experienced chronic ringing in the ears? _____

YES NO Do you have sleep apnea or do you snore? _____

YES NO Have you had your tonsils or adenoids removed? _____

YES NO If the patient is under age 16, height of parents? Mom _____ Dad _____

YES NO Are you aware that some appointments will be during school/work hours? _____

Please list some hobbies or interests _____

Female Patients Only:

YES NO Are you pregnant? _____

YES NO Has menstruation started? _____

Reviewed By: _____ Date: _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body party and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

Signature: _____ Date: _____