Orthodontic Specialists
Of Mid-Michigan
—Orthodontics for Children and Adults—
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Comprehensive Patient Registration Record

All Information Listed is
STRICTLY CONFIDENTIAL

PATIENT INFORMATION—ADULT

Patient's Name: _____ Preferred Name: _____

Birth date: _____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City/State/Zip: _____

Home Phone: _____ Email: _____

Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Are there other family members that come to our office? _____

Dentist Name: _____ Who can we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Social Security #: _____ Birth date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

PRIMARY Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name _____

Relationship to Patient: _____

Insured's SS# _____

Insured's Birth date: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group #: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

SECONDARY Dental Insurance:

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name _____

Relationship to Patient: _____

Insured's SS# _____

Insured's Birth date: _____

Insured's Employer: _____

Insurance Co. Name: _____

Subscriber ID#: _____

Insurance Co. Group #: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone #: _____

MEDICAL HISTORY

Please indicate whether or not you have ever had any of the following medical conditions by circling (y)es (n)o.

Y	N	ADD/ADHD	Y	N	Emotional Problems	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Epilepsy/Seizures	Y	N	Oral Ulcer
Y	N	Arthritis	Y	N	Headache/Migraine	Y	N	Previous Surgery
Y	N	Artificial Joints/Valves	Y	N	Heart Condition/Murmur	Y	N	Rheumatic Fever
Y	N	Asthma/Difficulty Breathing	Y	N	Hemophilia/ Abnormal	Y	N	Thyroid Problems
Y	N	Birth/Congenital Defects	Y	N	Bleeding	Y	N	Tuberculosis
Y	N	Cancer	Y	N	Hepatitis	Y	N	Tonsils removed–Age:
Y	N	Cold Sores	Y	N	Herpes	Y	N	Adenoids Removed–Age:
Y	N	Diabetes	Y	N	HIV positive	Y	N	Mouthbreather
Y	N	Endocrine Problems	Y	N	Kidney/Liver Problems	Y	N	Women: Are you pregnant

ALLERGIES: Medications— Y or N If yes, please list. _____

Latex— Y or N Metals— Y or N Plastic/Acrylic— Y or N

Other— Y or N If yes, please list. _____

Are you currently being seen for any injury or illness? Y or N If yes, please explain: _____

Are there any other medical concerns we should be aware of? Y or N If yes, please explain: _____

Do you need to be pre-medicated prior to dental visits? Y or N If yes, do you have prescription filled? Y or N

Name of Physician: _____ Phone: _____

Please list any medication(s) you are currently taking, along with reason for the medication(s):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ADULT DENTAL AND TEMPROMANDIBULAR JOINT HISTORY

When did you last visit the dentist? _____

Why are you seeking an orthodontic consultation? _____

Have you had a prior orthodontic consultation or treatment? Y or N—If yes, Date: _____ Dr: _____

Do you have any speech problems? Y or N—If yes, are you currently in speech therapy? Y or N

Have you ever had a severe head, neck or facial injury? Y or N—If yes, please explain: _____

Do you have:

- Difficulty in mouth opening? Y or N—If yes, please explain: _____
- Pain or clicking in the jaw joint? Y or N—If yes, please explain: _____
- Pain on chewing, yawning, or wide opening? Y or N—If yes, please explain: _____
- Pain in or about the ears or cheeks? Y or N—If yes, please explain: _____
- A bite that feels “uncomfortable” or “unusual”? Y or N—If yes, please explain: _____
- A jaw that “locks”, “gets stuck”, or “goes out”? Y or N—If yes, please explain: _____
- Noises in or from the jaw joints? Y or N—If yes, please explain: _____

The following habits are of interest. List information as it pertains to you:

- Thumb/finger/lip sucking until _____ age Y or N—If yes, please explain: _____
- Grinding or clenching of teeth? Y or N—if yes, please explain: _____
- Tongue thrusting or other functional problem? Y or N—If yes, please explain: _____

Have you been informed of any missing or extra permanent teeth? Y or N—If yes, please explain: _____

I authorize X-rays and Diagnostic Photos to be taken for diagnostic purposes to be able to give you the most accurate information possible at the Initial Examination appointment.

I have read and understand the above questions. I will not hold my orthodontist(s) or any member of their team responsible for any errors or omissions that I have made in the completion of this form. I understand that it is my responsibility to contact this office with any changes in my medical/dental status.

Signature of Patient: _____ Today’s Date: _____