Antigua Orthodontics

Dr. Rebecca A. Faunce D.M.D.

Adult Registration and History

Patient's Name (Mr.,Ms.,Mrs.,Miss)_____

Birth Date_____ SS#_____ Male/Female_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell_____

Employer_____ Occupation_____ Email_____

Spouse's Name/Incase of Emergency Call_____

Whom may we thank for referring you _____

How did you hear about our office.(Phone Book,Internet,facebook,etc)_____

Dental Insurance

Primary Subscriber's Name_____ DOB_____

SS#_____ Insurance Company_____

Group#_____ ID#_____ Ins. Phone_____

Secondary Subscriber's Name_____ DOB_____

SS#_____ Insurance Company_____

Group#_____ ID#_____ Ins. Phone_____

Dental History

Dentist Name_____ Phone_____

Date of Last Dental Visit_____ For What Service_____

YES NO

□ □ Are you having any discomfort. If yes explain_____

□ □ Any serious trouble associated with treatment. If yes explain_____

□ □ Any injuries to: Mouth-Teeth-Head. If yes explain_____

□ □ Does dental treatment make you nervous. If yes explain_____

□ □ Have you ever been treated for periodontal disease. (Gum Disease,Pyorrhea,Trench Mouth) If yes explain_____

□ □ Any lost teeth. If yes explain_____

□ □ Have missing teeth been replaced. If yes explain_____

How often do you brush_____ floss_____ Toothbrush is Soft____, Medium____, Hard____.

□ □ Orthodontic appliances worn now or ever been worn _____

□ □ Any family member that is in or has had orthodontic treatment with our office. If yes which office and name of family member/s _____

Do you have or have you ever had any of the Following:

Mouth

YES NO

□ □ Bleeding, Sore Gums
□ □ Unpleasant Taste/Breath
□ □ Burning Tongue/Lips
□ □ Frequent Blisters, Lip/Mouth
□ □ Swelling/Lumps in Mouth
□ □ Biting Cheeks/Lips
□ □ Clicking/Popping Jaw
□ □ Difficulty Opening or Closing Jaw

Teeth

YES NO

□ □ Loose Teeth
□ □ Sensitive to Hot
□ □ Sensitive to Cold
□ □ Sensitive to Sweets
□ □ Sensitive to Biting
□ □ Clenching/Grinding. if yes_____
□ □ Food Impaction
□ □ Shifting/Change in Bite

Health History

Physician's Name_____ Phone_____

Date of last physical examination_____ Results_____

YES NO

□ □ Are you under care of a physician now_____

□ □ Are you receiving any medications or drugs. If yes explain _____

□ □ Have you had excessive bleeding (extraction, surgery, trauma)_____

□ □ Have you been hospitalized in the past 5 years. If yes explain_____

□ □ Have you had surgery in the past 5 years. If yes explain _____

□ □ Has there been any changes in your general health within the past year. If yes explain_____

□ □ Allergies to **ANY** drugs. If yes explain_____

□ □ Allergies to **ANY**: Food-Pollen-Animals-**Latex**-Other _____

□ □ Do your ankles swell_____

□ □ Are you ever short of breath after mild exercise_____

□ □ Do you have pain in chest upon exertion_____

□ □ Do you get short of breath when you lie down, or do you require extra pillows when you sleep_____

□ □ Do you urinate(pass water) more than six times a day_____

□ □ Are you thirsty much of the time_____

□ □ Does your mouth frequently become dry_____

□ □ Have you ever tested positive for the AIDS Virus._____

□ □ Have you ever required a blood transfusion. If yes explain_____

□ □ Have you ever had a persistent cough or coughed up blood. If yes explain_____

□ □ Do you use any tobacco products. If yes explain how much per day_____

□ □ Do you use any alcohol products. If yes explain how much per week_____

□ □Do you use any caffeinated products. If yes explain how much per day_____

□ □ Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation. If yes explain_____

□ □ Are you experiencing stress or pressure in your work or at home_____

□ □ May we request release of your medical records_____

WOMEN ONLY

□ □ Are you pregnant _____□ □ Are you taking birth control or hormone therapy_____

□ □ Do you have PMS or problems associated with your menstrual period._____

Do you have or have you had any of the following diseases or problems:

YES	NO		YES	NO		YES	NO	
□	□	Anemia	□	□	Arthritis	□	□	Arteriosclerosis
□	□	Asthma	□	□	Bladder	□	□	Blood Pressure (high/low)
□	□	Bruise Easily	□	□	Cerebral Palsy	□	□	Chicken Pox
□	□	Chronic Sinus	□	□	Cardiovascular Disease	□	□	Congenital Heart Disease
□	□	Convulsions	□	□	Coronary Insufficiency	□	□	Diabetes
□	□	Digestive System(Ulcers or Stomach)	□	□	Epilepsy	□	□	Fainting
□	□	Hearing	□	□	Heart Trouble	□	□	Heart Attack
□	□	Heart Murmur	□	□	Hepatitis	□	□	Immune System (AIDS,HIV,ARC)
□	□	Inflammatory Rheumatism	□	□	Jaundice	□	□	Kidney Trouble
□	□	Liver Disease	□	□	Malignancies	□	□	Mastoid
□	□	Measles	□	□	Mononucleosis	□	□	Mumps
□	□	Pacemaker	□	□	Rheumatic Fever	□	□	Rheumatic Heart Disease
□	□	Stroke	□	□	Sinus trouble	□	□	Seizures
□	□	Thyroid	□	□	Tuberculosis	□	□	Venereal Disease
□	□	Artificial or replacement valve	□	□	Artificial or replacement joints	□	□	wear contact lenses

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

_____

_____

Doctors Summary:

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient_____ **Date**_____

Signature of Dentist_____ **Date**_____