ADULT PATIENT REGISTRATION

the office of Bridget Powers, D.D.S.,M.S.

TODAY'S DATE_____

PERSONAL INFORMATION

Name_____Gender_____Age_____Date of birth_____

Nickname (likes to be called) _____

Address_____

City, Zip_____

Email Address – for office use only_____ or_____

Home Phone_____Cell Phone_____

Person to contact in case of emergency_____

Relationship_____Contact phone_____

General dentist_____

Whom may we thank for mentioning our office? _____

Did you visit our website before this appointment? Y N Was that important to your decision? Y N

Have you had previous orthodontic consultation or treatment? _____

What is the main reason you seek this consultation? _____

MEDICAL HISTORY

While orthodontic treatments are obviously primarily confined to the mouth, your overall health status and medications you may be taking do have an effect on oral tissues and the biology of tooth movement. Therefore, we ask that you complete this part of the form and describe or explain questions you answer "yes". Dr. Powers will review this with you at the examination.

Name of your physician_____Date of last visit_____

Are you:

Presently under any medical care or taking any medications? Y N Please explain:

_____

Any Allergies? _____

Are there any matters you would like to discuss in private?

_____

Any of the following (please circle)

Rheumatic fever	Attention deficit disorder	Endocrine disorder
Congenital heart lesions	Diabetes	Cancer
Heart trouble	Asthma	Immune system problems
High blood pressure	Tuberculosis (TB)	Hepatitis
Heart murmur	Arthritis	Other blood borne disease
Heart surgery	Bone disorder	Prolonged bleeding
Fainting	Neurological disorder	Hemophilia
Epilepsy/convulsions	Blood transfusion	Tonsil or Adenoids removed
Difficulty falling asleep	Snoring	Sleep Apnea
HIV	Enlarged adenoids or tonsils	Difficulty breathing

Is there any other medical history which has not been covered on this form? _____

_____

_____

DENTAL HISTORY

General dentist_____ Date of last dental visit_____

How often do you see the dentist? _____

Decay /cavity experience? _____none _____limited _____extensive

Y N Do you clench or grind your teeth at night?

Y N Do you breathe mainly through your mouth?

Y N Do you have or did you have thumb or nail-biting habits? Until what age: _____

Y N Do you smoke or use tobacco in any other form?

Y N Do you have any metal rods or implants?

Y N Have you ever taken Phen-Fen? (also known as Redux or Pondimin)

Y N Have you ever taken Fosamax or any other bisphosphonate?

Y N Are you aware of any naturally missing permanent teeth?

Y N Women: Are you pregnant?

Y N Women: Are you nursing?

Y N Women: Are you using a prescribed method of birth control?

Y N Are you aware of clicking, catch, popping or noises in jaw joints?

Y N Do you have pain in or about your ears, temples, or cheeks?

Y N Do you have pain or difficulty when chewing, talking, or using your jaw?

Y N Do your jaw get "stuck", "locked", or "go out"?

Y N Do you have frequent headaches?

Y N Do you have speech difficulties?

Y N Do you have gums that bleed?

Y N Have you ever worn a bite plate or other orthodontic appliances?

Y N Do you take antibiotics before dental procedures?

Y N Is there any other dental related history which might affect orthodontic treatment?

Y N Have you seen any dental/orthodontic specialists? Please explain _____

_____

Our office is HIPAA compliant and is committed to meeting the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical/dental status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services I may need. I also authorize Dr. Powers and Smile Power Orthodontics to mail/email her exam findings to my/my child's dentist and myself.

Signature_____Date_____

Relationship to
patient_____