Dr. Cathleen George

Release the perfect smile®

ADULT REGISTRATION

PERSONAL DETAILS

Today's Date: ___ / ___ / ___ (MM / DD / YYYY)

Email Address: ______________________

Name: ______________ ______________ ____ ________
Last First Mi Title

I prefer to be called: ______________ ☐Male ☐Female

Birthdate: ___ / ___ / ___ (MM / DD / YYYY) Age: ______ SS#: ______________

Home Address: ______________________
Apt/Condo#

______________ ______________ ______________
City State Zip

☐Single ☐Married ☐Partnered ☐Divorced/Separated ☐Widowed

Home#: ______________ Cell#: ______________

Work#: ______________ Ext: ________

Employer: ______________________

Where and when is the best time to reach you? ______________

Whom may we thank for referring you? ______________

Names of other family members with us: ______________

Current/Previous Dentist: ______________

Person Responsible for Account: ______________

Relation: ______________ Tel#: ______________

EMERGENCY CONTACT

Name: ______________ ______________ ____ ________
Last First Mi Title

Home#: ______________ Cell#: ______________

Work#: ______________ Ext: ____ Relation: ______________

ORTHDONTIC INSURANCE

Primary

Do you have orthodontic coverage? ☐Yes ☐No

Do you have dental coverage? ☐Yes ☐No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

______________ ______________ ______________
City State Zip

Insurance Co. Contact#: ______________________

Group/Plan/Local/Policy#: ______________________

Insured's Name: ______________________

Relation: ______________ Birthdate: ___ / ___ / ___ (MM / DD / YYYY)

Insured's SS#: ______________ Insured's ID#: ______________

Secondary

Do you have orthodontic coverage? ☐Yes ☐No

Do you have dental coverage? ☐Yes ☐No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

______________ ______________ ______________
City State Zip

Insurance Co. Contact#: ______________________

Group/Plan/Local/Policy#: ______________________

Insured's Name: ______________________

Relation: ______________ Birthdate: ___ / ___ / ___ (MM / DD / YYYY)

Insured's SS#: ______________ Insured's ID#: ______________

MEDICAL HISTORY

Your current physical health is? ☐ Good ☐ Fair ☐ Poor

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ____________________

Physician's Tel#: ____________ Last Visit: MM / YYYY

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____________________

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever had any metal rods, pins, or implants? ☐ Yes ☐ No

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list each one: ____________________

Have you ever taken Fosamax or any other bisphosphanate? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Abnormal Bleeding/Hemophilia	Y	N	Herpes/Fever Blisters
Y	N	AIDS	Y	N	High Blood Pressure
Y	N	Alchohol/Drug Abuse	Y	N	HIV
Y	N	Anemia	Y	N	Hospitalized For Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Disease
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Blood Transfusion	Y	N	Lupus
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Pacemaker
Y	N	Congenital Heart Defect	Y	N	Psychiatric Problems
Y	N	Diabetes	Y	N	Radiation Treatment
Y	N	Difficulty Breathing	Y	N	Rheumatic/Scarlet Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting Spells	Y	N	Sickle Cell Disease/Traits
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack/Surgery	Y	N	Tuberculosis (TB)
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

____

____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Penicillin
Y	N	Codeine	Y	N	Jewelry/Metals	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Other

Please list any other drugs/materials that you are allergic to:

____

____

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No If yes, week#: ________

Are you nursing? ☐ Yes ☐ No

DENTAL HISTORY

What are the main concerns that you would like orthodontics to resolve?

____

____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Do you have any speech problems? ☐ Yes ☐ No

If yes, please explain: ____________________

Do you have any missing or extra permanent teeth? ☐ Yes ☐ No

Do you generally breathe through your mouth? ☐ Yes ☐ No

If yes, please indicate: ☐ While Awake ☐ While Asleep

Have you ever had an injury to any of the following? ☐ Mouth ☐ Teeth ☐ Chin ☐ None

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change? ____________________

____

____

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

I hereby declare that, to the best of my knowledge, the information provided in this form is true and accurate. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

____________________ ____________

Parent/Guardian Signature Date

OFFICE USE ONLY

I hereby declare that I have verbally reviewed the dental and medical information above with the patient named herein.

____________________ ____________

Orthodontist Signature Date

Comments: ____________________

____

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since their last visit? ☐ Yes ☐ No

If yes, please explain: ____________________

____

Parent/Guardian Signature ________ Date ________

Orthodontist Signature ________ Date ________

Has there been any change in your child's health status since their last visit? ☐ Yes ☐ No

If yes, please explain: ____________________

____

Parent/Guardian Signature ________ Date ________

Orthodontist Signature ________ Date ________