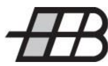

Orthodontic Registration and Acquaintance Card - ADULT

Name: ______________________ **Preferred Name:** ______________________

Date of Birth: ____/____/____ **Age:** _____ **Gender:** ____ **Home Phone:** ________________ **Mobile Phone:** ________________

Address: ______________________ **City:** ________________ **State:** _____ **Zip:** ____________

Dentist: ______________________ **Physician:** ______________________

Whom may we thank for referring you to our practice? ______________________

What is the primary concern about your teeth? ______________________

MEDICAL HISTORY *(Circle all current and past conditions)*

Heart Attack / Heart Disease
Heart Murmur
Rheumatic Fever
Stroke
High or Low Blood Pressure
Bleeding Disorder / Anemia
Asthma
Emphysema
Tuberculosis
Diabetes
Ear/Nose/Throat/Sinus Problems
Endocrine / Thyroid Problems
Hepatitis / Liver Disease
Kidney or Bladder Disease
Cancer
Osteoporosis
Epilepsy / Seizures
Arthritis
Joint Swelling
Skin Disease
MRSA
Allergies
HIV+ / AIDS
Psychological / Emotional Problems
Eating Disorder
Glaucoma
Headaches / Migraines
Other (please list) ____________________

____

DENTAL HISTORY *(Circle all that apply)*

Injuries to Teeth and/or Face (Describe)____________________
Finger/Thumb Sucking
Lip Biting
Mouth Breathing
Jaw Joint (TMJ) Clicking/Locking/Pain
Grinding or Clenching Teeth
Fillings/Caps/Crowns/Veneers (Describe)____________________
Root Canals (Describe)____________________
Teeth Pulled (Describe)____________________
Other Oral or Facial Surgery (Describe)____________________
Periodontal (Gum) Treatment (Describe)____________________
Oral Biopsy (Describe)____________________
Orthodontic Treatment (Describe)____________________
Tooth Bleaching
Cold Sores or Canker Sores

Please answer all of the questions that apply:
Medications taken regularly? (Describe) ____________________
Allergic to latex? Yes ____ No ____
Allergic to nickel? Yes ____ No ____
Use illegal drugs? Yes ____ No ____
Use tobacco in any form? Yes ____ No ____ (Describe)____________________
Ever had radiation treatment or chemotherapy? Yes ____ No ____
Ever taken a bisphosphonate medication (such as Fosamax or Boniva)? Yes ____ No ____
Date of last visit to dentist, and for what purpose? ____________________
____
Date of last visit to physician, and for what purpose? ____________________
____
(women) Are you pregnant? Yes ____ No ____

Is there anything else we should know about your medical, dental, or psychological history? ____________________

Orthodontic Insurance Company: ________________ **Policy #:** ____________ **Group #:** ____________

Employer: ______________________ **Work Phone:** ________________

Name of insured employee: ______________________

Person to Notify in Case of Emergency: ________________ **Relationship:** ________ **Phone #:** ____________

To the best of my knowledge the above information is complete and correct. I hereby give permission to Dr. David M. Bunkall to examine me and secure orthodontic diagnostic records. I also give Dr. Bunkall permission to verify my insurance coverage and, at his discretion, to run a credit check.

Signature ______________________ **Date** ________________