

ADULT PATIENT REGISTRATION
WILSON ORTHODONTICS
(please print)

Date _____

Patient's First Name _____ **Middle Initial** _____ **Last Name** _____ **Home Phone #** _____

Patient's Address _____ **City** _____ **State** _____ **Zip** _____

Sex _____ **Miss/Mrs/Ms/Mr. (circle one)** **Age** _____ **Birthdate** _____

Patient's Employer _____ **Length of Employment There** _____

Patient's Business Phone _____

Spouse's Name _____

Spouse's Address (if different from pt.) _____ **Phone** _____

City _____ **State** _____ **Zip** _____

Spouse's Employer _____ **Length of Employment** _____

Spouse's Business Phone _____

Marital Status: (circle one) **Married** **Single** **Separated** **Widowed** **Divorced**

Name of Person Responsible for Account _____ **Relationship to Patient** _____

Patient's Dental Insurance Company _____ **Group #** _____

Spouse's Dental Insurance Company _____ **Group #** _____

Which of these is the primary dental carrier? _____

Patient's Dentist _____ **Patient's Physician** _____

Were you referred to our office by another patient? Name: _____

Please understand that we may have to have you miss work on occasion for appointments which require more time.

Do we have your permission to share any information, including financial, with your spouse? **Yes** _____ **No** _____

I hereby acknowledge that I have read and understand this form and that all the information I have given above is accurate to the best of my knowledge.

Signed _____

PLEASE COMPLETE HEALTH HISTORY ON THE BACK OF THIS FORM

ALLERGIES:

Hay fever? Yes No
 Dental material? Yes No
 Latex? Yes No
 Drugs? Yes No
 Please list _____

SERIOUS ILLNESSES:

Diabetes? Yes No
 Epilepsy? Yes No
 Polio? Yes No
 Tuberculosis? (TB) Yes No
 Rheumatic Fever? Yes No
 Heart damage? Yes No
 Heart murmur? Yes No
 Hemophilia Yes No
 Radiation treatment? Yes No
 Hearing difficulty? Yes No
 Recurrent earaches? Yes No
 Thyroid condition? Yes No
 Recurrent sore throat? Yes No
 AIDS or HIV? Yes No
 Hepatitis? Yes No
 Birth defects? Yes No
 Other illnesses _____

SERIOUS INJURIES:

Ever had head injury? Yes No
 Face injury? Yes No
 Tooth injury? Yes No
 Brief description of injury _____

OPERATIONS/HOSPITALIZATIONS:

Tonsils removed? Yes No
 Adenoids removed? Yes No
 Blood transfusions? Yes No
 Other: _____

Joint replacement/Prosthetic Implant?
 Yes No

Are you currently taking any medications? Yes No Please list medications _____

Are you currently under a doctor's care? Yes No If yes, please explain _____

Have you had previous orthodontic treatment? Yes No

Do you have any disease not listed above? Yes No If yes, please explain _____

Do you require premedication for heart murmur? Yes No

I HAVE READ AND UNDERSTAND THIS MEDICAL HISTORY. I WILL NOT HOLD THE OFFICE OF TIMOTHY G. WILSON RESPONSIBLE FOR ANY OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM AND, IF THERE ARE ANY CHANGES TO THIS MEDICAL HISTORY, I WILL NOTIFY THE OFFICE AS SOON AS I AM AWARE OF THEM.

SIGNED _____ **DATE** _____ **DR.** _____

MUSICAL INSTRUMENT: _____

SPORTS: _____

FEMALE PATIENTS ONLY:

Is it possible that you could be pregnant? Yes No

BREATHING DIFFICULTIES? Yes No

Explain _____

SPEECH:

Speech problems? Yes No

Speech therapy? Yes No

Explain _____

GAGGING PROBLEM: Yes No

DENTAL HEALTH:

Date of last dental visit: _____

Jaw noises? (clicking/etc.) Yes No

Jaw/face pain? Yes No

TMJ problems? Yes No

Bleeding gums? Yes No

Any fillings? Yes No

ORAL HABITS:

Thumb/finger sucking habit? Yes No

Is this a current habit? Yes No

Grinding of teeth? Yes No

Chewing difficulties? Yes No