



ADULT PATIENT REGISTRATION

TODAY'S DATE: _____

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Specialist in Orthodontics for Children & Adults

Full Name: _____ Nickname _____ DL#: _____
Male/Female (Circle) Birthdate: _____ Age: _____ SS #: _____
Marital Status: ___ Single ___ Married ___ Widowed ___ Divorced ___ Separated
Home Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Work#: _____ Other#: _____
Employer: _____ Occupation: _____ How long there? _____
Employer's address: _____ City: _____ State: _____ Zip: _____
When and where are the best times to reach you? _____
What is the best way to contact you regarding appointments? ___ E-mail ___ Phone
E-mail address(s): _____

Whom may we thank for your referral? ___ Phonebook ___ Insurance Co ___ Dentist _____ Friend _____
Website ___ If Internet, what did you Google? _____ Other _____

Name of Spouse/closest relative _____ Relation to You (if not spouse) _____
Home Address: _____ City: _____ State: _____ Zip: _____
Home#: _____ Cell#: _____ Work#: _____ Other#: _____

Person(s) Financially Responsible for Acct:

Name(s): _____ Relation to patient: _____
Billing Address: _____
City: _____ State: _____ Zip: _____ SS #: _____ DL #: _____
E-Mail: _____ Home #: _____ Cell/Other #: _____
Employer: _____ Work #: _____ Ext: _____

Insurance Information:

Primary:

Secondary:

Ins. Co. Name:	_____	_____
Phone #:	_____	_____
Ins. Co. Address:	_____	_____
Insured's Name:	_____	_____
Relationship to Patient:	_____	_____
Insured's Birthday & SS#	_____	_____
Insured's Employer:	_____	_____
Effective Date:	_____	_____
Contract # / Group #	_____	_____
Lifetime Max:	_____ Payable @ %: _____	_____ Payable@%: _____
Age Limit / Waiting Period	_____	_____

DENTAL HISTORY:

Dentist Name _____ Last Visit _____ For what service? _____

Your current dental health is ___ Good ___ Fair ___ Poor

Now or in the past have had:

Permanent or "extra" teeth removed ?	Y/N	Chipped or injured baby or permanent teeth?	Y/N
"Extra" or congenitally missing teeth ?	Y/N	Teeth sensitive to hot or cold; teeth throb or ache?	Y/N
Bleeding gums, bad taste or mouth odor problems ?	Y/N	Ever had Periodontal / Root canal Treatment ?	Y/N
Frequent cancer sores or cold sores ?	Y/N	Any teeth irritating cheek, lip, tongue or palate ?	Y/N
Tooth grinding or jaw clenching problems ?	Y/N	Ever been treated for TMD or TMJ problems ?	Y/N
Mouth breathing habit, snoring or difficulty breathing ?	Y/N	Abnormal swallowing habit (tongue thrusting) ?	Y/N
Food impaction between teeth ?	Y/N	Finger, thumb, or other sucking habit ?	Y/N
History of speech problems ?	Y/N	Any serious trouble with previous dental work ?	Y/N
Aware or concerned about an under or over-developed jaw ?	Y/N	Any relative with similar tooth or jaw relationships ?	Y/N
Any jaw fractures, or other injuries to mouth or face ?	Y/N	Ever had a prior orthodontic examination or treatment ?	Y/N

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

MEDICAL HISTORY:

Your current physical health is ___Good ___Fair ___Poor

Are you currently under the care of a physician ? Y/N Please explain _____

Physician's Name: _____ Phone: _____ Date of last visit: _____

Are you taking any prescription / over-the-counter drugs ? If so, please list them:

Medication: _____	Taken for: _____
Medication: _____	Taken for: _____
Medication: _____	Taken for: _____

Allergies or reactions to any of the following ?

Ibuprophen (Advil, Motrin), aspirin, acetaminophen (Tylenol), please specify _____

Penicillin, erythromycin, tetracycline, dental anesthetics, please specify _____

Plastics, acrylics, vinyls, metals, please specify _____

Other, please specify _____

Now or in the past, have you had: (please circle)

Drug / alcohol abuse / chewing or smoking tobacco ?	Y/N	Psychiatric / behavioral problems ?	Y/N
Bone fractures or any major accidents ?	Y/N	Artificial joints / plates / bones ?	Y/N
Hayfever, asthma, sinus trouble or hives ?	Y/N	Ear, nose, or throat conditions ?	Y/N
Thyroid/adenoid /tonsil condition ?	Y/N	Birth defects or hereditary problems ?	Y/N
Vision, hearing, tasting or speech difficulties ?	Y/N	History of eating disorder (anorexia, bulimia) ?	Y/N
Abnormal bleeding (hemophilia) or bruising tendency ?	Y/N	Ulcers / colitis / anemia / tires easily ?	Y/N
Hepatitis, jaundice or liver problems ?	Y/N	Kidney problems ?	Y/N
Endocrine or Thyroid problems ?	Y/N	Diabetes ?	Y/N
Epilepsy, seizures, fainting spells or neurological problems ?	Y/N	Severe or frequent headaches ?	Y/N
Rheumatoid or arthritic conditions ?	Y/N	Polio, mononucleosis, TB or pneumonia?	Y/N
Skin disorders ?	Y/N	Shingles ?	Y/N
Cancer, tumor, radiation treatment, or chemotherapy ?	Y/N	Problems with immune system ?	Y/N
HIV positive or AIDS ?	Y/N	Blood transfusion ?	Y/N
Venereal disease ?	Y/N	Heart attack or stroke ?	Y/N
Chest Pain, shortness of breath or swelling of ankles ?	Y/N	High or Low blood pressure ?	Y/N
Heart surgery / pacemaker / artificial value ?	Y/N	Heart Murmer / mitral valve prolapse ?	Y/N
Are you pregnant ?	Y/N	Rheumatic Fever ?	Y/N
Operations / Hospitalizations ? _____			
Other problems or symptoms ? _____			

Acknowledgment: I have read and understand the above registration form. I will not hold Dr. Bertha Dieguez-Marino or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. In addition, I have received a copy of this office's notice of privacy practices.

Consent to undergo Orthodontic Treatment: I hereby consent to the making of diagnostic records, including x-rays, before, during and after orthodontic treatment prescribed by the doctor as well as to the staff and doctor providing the prescribed orthodontic treatment for the above patient. I fully understand all of the risks associated with treatment.

Assignment of benefits: I hereby give permission to bill my insurance company for the services rendered by Dieguez-Marino Orthodontics P.C., and I agree to assist in the processing all claims for benefits. I hereby authorize direct payment of benefits to Dieguez-Marino Orthodontics P.C.

Financial Responsibility: I hereby agree to be responsible for all charges for services rendered to the patient including any non-covered charges. I also agree that if the unpaid account is referred to a collections agency, to pay all costs of collections, including reasonable fees of one-third of the balance due.

Signed by Patient (Agreement to Pay)

Date: