MOURITSEN ORTHODONTICS

ORTHODONTIC PATIENT REGISTRATION

PATIENT#_____

PATIENT INFORMATION

PATIENT'S FULL NAME _____PATIENT'S DOB_____ AGE _____☐MALE ☐FEMALE

PATIENT'S ADDRESS _____CITY _____

STATE_____ZIP_____HOME PHONE_____CELL PHONE _____

PATIENT'S DENTIST_____DENTIST'S PHONE_____

WHOM MAY WE THANK FOR YOUR REFERRAL?_____

OTHER FAMILY MEMBERS SEEN BY US? _____

HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? TEXT EMAIL HOME (circle one)

RESPONSIBLE PARTY INFORMATION

PARTY 1 _____ (☐ SINGLE ☐MARRIED ☐ DIVORCED) RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____ HOME/CELL PHONE _____

EMPLOYER & OCCUPATION _____ DOB _____SSN _____

EMAIL ADDRESS _____ ___WORK PHONE _____

PARTY 2 _____ (☐ SINGLE ☐MARRIED ☐ DIVORCED) RELATIONSHIP TO PATIENT _____

HOME ADDRESS _____HOME/CELL PHONE _____

EMPLOYER AND OCCUPATION _____DOB _____SSN _____

EMAIL ADDRESS_____WORK PHONE _____

HEALTH HISTORY

MEDICAL HISTORY- PLEASE CHECK "YES" OR "NO" TO ALL ITEMS BELOW

☐ YES ☐ NO LATEX ALLERGIES

☐ YES ☐ NO NICKEL ALLERGY

☐ YES ☐ NO GIRLS: STARTED MENSTRUATION? FIRST CYCLE? _____

☐ YES ☐ NO ASTHMA (IF SO, WHAT MEDICATION(S)? _____

☐ YES ☐ NO HEPATITIS (IF SO, WHAT TYPE)? _____

☐ YES ☐ NO TUBERCULOSIS (TB)

☐ YES ☐ NO AIDS OR HIV

☐ YES ☐ NO EPILEPSY

☐ YES ☐ NO ARE YOU PREGNANT? HOW FAR ALONG? _____

☐ YES ☐ NO DRUG ALLERGIES WHICH ONES? _____

☐ YES ☐ NO DIABETES

☐ YES ☐ NO PROLONGED BLEEDING

☐ YES ☐ NO RHEUMATIC FEVER ☐ YES ☐ NO STOMACH ULCERS

☐ YES ☐ NO MONONUCLEOSIS ☐ YES ☐ NO GLAUCOMA

☐ YES ☐ NO HEART VALVE PROBLEMS ☐ YES ☐ NO ANEMIA

☐ YES ☐ NO HIGH BLOOD PRESSURE ☐ YES ☐ NO CANCER

☐ YES ☐ NO PALPITATIONS ☐ YES ☐ NO SPELLS OR DIZZINESS

☐ YES ☐ NO ARE YOU UNDER DOCTOR'S CARE NOW?

FOR WHAT? _____

NAME OF PHYSICIAN _____

PHYSICIAN'S PHONE _____

DENTAL HISTORY-PLEASE CHECK "YES" OR "NO" TO ALL ITEMS BELOW

DATE OF LAST CLEANING _____

☐ YES ☐ NO ANY INJURIES TO ☐ FACE ☐MOUTH ☐TEETH? WHAT AGE _____

☐ YES ☐ NO THUMB, FINGER, OR LIP SUCKING HABIT(S)? WHAT AGE _____

☐ YES ☐ NO MOUTH BREATHING WHEN ☐AWAKE ☐ ASLEEP?

☐ YES ☐ NO A TONGUE THRUST PROBLEM? ☐ SPEECH PROBLEM?

☐ YES ☐ NO ANY CLENCHING OR GRINDING OF TEETH? ☐ DAY ☐ NIGHT

☐ YES ☐ NO ANY PAIN, POPPING OR LOCKING ON OPENING/ CLOSING JAW?

☐ YES ☐ NO TEMPOROMANDIBULAR JOINT PAIN (TMJ)

☐ YES ☐ NO FREQUENT HEADACHES?

☐ YES ☐ NO ANY MUSCLE TENDERNESS/ STIFFNESS IN THE☐JAW ☐ NECK?

☐ YES ☐ NO ANY RINGING SOUNDS IN THE EAR?

☐ YES ☐ NO ANY PREVIOUS TREATMENT FOR TMJ OR JAW PROBLEMS?

☐ YES ☐ NO AND PREVIOUS ORTHODONTIC EVALUATION OR TREATMENT?

☐ YES ☐ NO ARE YOU TAKING BISPHOSPHONATES (OSTEOPOROSIS MEDS)?

☐ YES ☐ NO ARE YOU TAKING ADVIL, MORTIN, OR TYLENOL DAILY?

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH

_____

_____

SIGNATURE OF PERSON COMPLETING FORM _____ DATE _____