Greatorthodontics

greatorthodontist@gmail.com

Today's Date_____

Patient Name:_____Preferred Name:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone Number:_____Cell Phone:_____

Date of Birth:_____E Mail Address:_____

General Dentist:_____Phone Number:_____

PARENT INFORMATION

Parent Responsible for Account:_____

Address:_____City:_____State:_____Zip Code:_____

Home Number:_____Work Number:_____Cell Number:_____

Date of Birth:_____Parent Social Security Number:_____

Employer:_____City:_____State:_____Zip Code:_____

*** INSURANCE INFORMATION***

Insurance Company

Name:_____

Address:_____City:_____State:_____Zip Code:_____

Phone Number:_____Fax Number:_____

Subcriber ID:_____ Group Number:_____

Whom may we thank for referring you to our practice?_____
Questions or concerns regarding treatment_____

Signature:_____Date:_____

976 E. Railroad Avenue | Bryn Mawr | Pennsylvania 19010
P: 610.525.2277 F: 610.525.1956

1646 West Chester Pike | West Chester | Pennsylvania 19382
P: 610.692.5590 F: 610.692.9454

DENTAL HEALTH HISTORY
(Confidential)

Today's Date_____

Patient Name_____ Birthdate_____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit_____

Former Dentist_____

Address_____

Date of last dental care_____ Date of last dental X-rays_____

Check (✓) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss?_____ How often do you brush?_____

MEDICAL HISTORY

Physician's Name_____ Date of Last Visit_____

Have you had any serious illnesses or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Greatorthodontics

Registration Form

greatorthodontist@gmail.com

Complete top of form only

Today's Date _____

Patient Name _____ Date of Birth_____

Mother's Name _____Work # _____ Cell # _____

Address _____

City _____ State _____ Zip Code _____

E mail Address _____

Questions or concerns regarding treatment?_____

Who can we thank for referring you to our office?_____

Orthodontic Evaluation

Angle Class 1_____ II_____ III_____

Skeletal Problem _____

Dental Problem _____

Over Bite% _____ Overjet% _____

Open Bite _____ Midlines _____ TMJ _____

Crossbite _____

Crowding _____Spacing _____

Impacted Teeth _____ Missing Teeth _____

Problems:

Treatment:

Fee:

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