

MONTICELLO FAMILY DENTISTRY  
ADULT ORTHODONTIC REGISTRATION FORM

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_

Telephone \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Social Security # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Do you have orthodontic insurance? YES NO If Yes, name & address of insurance company:

\_\_\_\_\_ Maximum \_\_\_\_\_ Ded. \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Family Physician \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient's Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Father's Ht. \_\_\_\_\_ Mother's Ht. \_\_\_\_\_

Does father have normal teeth? \_\_\_\_\_ Treated orthodontically? \_\_\_\_\_

Does mother have normal teeth? \_\_\_\_\_ Treated orthodontically? \_\_\_\_\_

Does brother or sister have orthodontic problem? \_\_\_\_\_ Treated? \_\_\_\_\_

Names of family members who are or were patients in our office: \_\_\_\_\_

Any injuries or operations involving head or face? \_\_\_\_\_

Are you taking any medications? YES NO If Yes, what? \_\_\_\_\_

Any difficulty chewing or swallowing? \_\_\_\_\_ Breathing through nose? \_\_\_\_\_

Any pain or noise when opening or closing mouth? \_\_\_\_\_

Have you had or do you have any of the following:

Allergies _____	Asthma _____	Nasal/Sinus Difficulty _____
Blood Disorder _____	Tonsilitis _____	AIDS/HIV _____
Heart Murmurs _____	Hepatitis (HBV) _____	Rheumatic Fever _____

Any other medical problems? \_\_\_\_\_

Any oral habits: Thumb Sucking \_\_\_\_\_ Mouth Breathing \_\_\_\_\_

Reason for orthodontic treatment: \_\_\_\_\_