This is a fillable form: Please download first, then type your information & print.

Pediatric Dentistry and Orthodontic Specialists

Adult Registration

Full Name________________________________
DOB_____________________________Age_____
Address __________________________________
City_________________State______Zip______
Home Phone # ____________________________
Mobile Phone #____________________________
Email Address:____________________________
Driver's License # _________________________
Business Phone# __________________________
Business Address___________________________
City________________State_________Zip______

Spouse Name_____________________________________
Employer _______________________________________
Business Address ________________________________
City____________________State________Zip_________
Business Phone ________________________Ext. ______
Position____

Who May we thank for referring you to our practice? ____
Have we treated any of your Family members? ____

Where have you seen or heard about our practice? (please check all that apply)
☐Pediatrician _____________________ ☐Your Dentist ___________________ ☐Community Event __________________
☐Friend/Neighbor___________________ ☐School Sponsorship/Event ____
☐Our website (www.pdospecialists.com)
☐Yelp ☐ Facebook ☐ Internet Search ☐Other____

If you would like us to assist you in filing your insurance claim please complete the following information. If you are the patient receiving care, your insurance is the primary carrier and your spouse's is the secondary. If the patient is a child (dependent), the primary carrier is the parent whose birth month is closest to the beginning of the year.

Primary Carrier

Name of Insured________________________
Social Security # _______________________
Insurance Carrier______________________
Employer ______________________________
Group#______________Union/Local______

Secondary Carrier

Name of Insured ____________________________
Social Security # ____________________________
Insurance Carrier ____________________________
Employer ____________________________________
Group# _________________Union/Local________

Emergency Contact Information

Name of Contact________________________ Relationship__________________________________
Phone Number__________________________

Name of Contact_______________________ Relationship__________________________________
Phone Number__________________________

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

____ ____________________________
Signed (Subscriber/Parent) Date

Patient Name ______________________________ **Your Physician** ______________________________
Date of Birth ______________________________ **Physician Phone #** ______________________________
Physician Address ____

Please check ☐ Yes ☐ No ☐ dk/u (don't know/understand) for each of the following

Now or in the past have you had:

☐Yes ☐ No ☐ dk/u Birth Defects or hereditary problems?
☐Yes ☐ No ☐ dk/u Bone fractures, any major accidents?
☐Yes ☐ No ☐ dk/u Rheumatoid or arthritic conditions?
☐Yes ☐ No ☐ dk/u Endocrine or thyroid problems?
☐Yes ☐ No ☐ dk/u Kidney problems?
☐Yes ☐ No ☐ dk/u Diabetes?
☐Yes ☐ No ☐ dk/u Cancer, tumor, radiation treatment or chemotherapy?
☐Yes ☐ No ☐ dk/u Stomach ulcers, acid reflux or heartburn?
☐Yes ☐ No ☐ dk/u Polio, mononucleosis,tuberculosis or pneumonia?
☐Yes ☐ No ☐ dk/u Artificial joints or heart valves?
☐Yes ☐ No ☐ dk/u Problems of the immune system?
☐Yes ☐ No ☐ dk/u AIDS or HIV positive?
☐Yes ☐ No ☐ dk/u Hepatitis, jaundice or liver problems?
☐Yes ☐ No ☐ dk/u Fainting spells, seizures, epilepsy?
☐Yes ☐ No ☐ dk/u Mental health issues or depression?
☐Yes ☐ No ☐ dk/u Vision, hearing, taste or speech difficulties?
☐Yes ☐ No ☐ dk/u Loss of weight recently or poor appetite?
☐Yes ☐ No ☐ dk/u History of eating disorder (anorexia, bulimia)
☐Yes ☐ No ☐ dk/u Excessive bleeding or bruising?
☐Yes ☐ No ☐ dk/u Blood disorders, clotting problems
☐Yes ☐ No ☐ dk/u High or low blood pressure?
☐Yes ☐ No ☐ dk/u Chronic fatigue syndrome
☐Yes ☐ No ☐ dk/u Chest pain, shortness of breath swelling in ankles
☐Yes ☐ No ☐ dk/u Cardiovascular problems (heart trouble, heart attack, chest pain, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur, rheumatic heart disease)
☐Yes ☐No ☐dk/u **If yes, to the previous question**, are you required to take antibiotics prior to dental care?
☐Yes ☐No ☐dk/u Skin disorders?
☐Yes ☐No ☐dk/u Frequent headaches, colds or sore throats?
☐Yes ☐No ☐dk/u Eye, ear, nose or throat condition?
☐Yes ☐No ☐dk/u Hayfever, asthma, sinus trouble or hives?
☐Yes ☐No ☐dk/u Are your tonsils present?
If removed, date of surgery: ___________
☐Yes ☐No ☐dk/u Osteoporosis?
☐Yes ☐No ☐dk/u Have you taken medications for Osteoporosis ? (Fosamax, Actonel, Boniva, Aredia, Zometa, Didronel)
☐Yes ☐No ☐dk/u History of substance abuse?

Please list all medications and supplements you are taking

Medication______________ Dose___________
Taken for ________________________________

Medication ______________Dose __________
Taken for ________________________________

Medication ______________Dose__________
Taken for________________________________

Medication ______________Dose __________
Taken for ________________________________

Medication_______________Dose __________
Taken for ________________________________

Medication ______________Dose __________
Taken for ________________________________

(If additional space is needed please ask)

Smoking

☐Yes ☐No ☐dk/u Do you smoke?
If yes: ☐ Tobacco or e-cigarettes ☐ Cannabis

For Women Only

☐Yes ☐No ☐dk/u Are you pregnant?
☐Yes ☐No ☐dk/u Are you taking birth control medication?

Allergies or reactions to any of the following:

☐Yes ☐No ☐dk/u Local Anesthetics
☐Yes ☐No ☐dk/u Aspirin
☐Yes ☐No ☐dk/u Ibuprofen (Motrin, Advil)
☐Yes ☐No ☐dk/u Acetominophen (Tylenol)
☐Yes ☐No ☐dk/u Penicillin or other Antibiotic ____________
☐Yes ☐No ☐dk/u Codeine or other narcotic
☐Yes ☐No ☐dk/u Nickel or other metals ________________
☐Yes ☐No ☐dk/u Latex (gloves, balloons)
☐Yes ☐No ☐dk/u Acrylic
☐Yes ☐No ☐dk/u Foods ______________________________
☐Yes ☐No ☐dk/u Dairy
☐Yes ☐No ☐dk/u Animals ____________________________

Is there any other information regarding your medical history that we should know?

Patient Signature ____Date:____________________

Dentist's Signature ____Date:____________________

Medical History

Your Dentist ______________________________
Office Phone # ____________________________
Office Address ____________________________

Patient Name ______________________________
Date of Birth ______________________________

Now or in the past, has the patient had:

☐Yes ☐ No ☐ dk/u Supernumerary or extra teeth?
☐Yes ☐ No ☐ dk/u Chipped or otherwise traumatized teeth?
☐Yes ☐ No ☐ dk/u Sensitivity to hot or cold?
☐Yes ☐ No ☐ dk/u Jaw fractures?
☐Yes ☐ No ☐ dk/u Pathology of the Jaw?
☐Yes ☐ No ☐ dk/u "Dead" teeth or root canal treatment?
☐Yes ☐ No ☐ dk/u Bleeding gums, bad taste or mouth odor?
☐Yes ☐ No ☐ dk/u Periodontal or "gum" problems?
☐Yes ☐ No ☐ dk/u Food impaction between teeth?
☐Yes ☐ No ☐ dk/u Frequent cold sores or ulcers?
☐Yes ☐ No ☐ dk/u Tooth abcess or "gum boils"?
☐Yes ☐ No ☐ dk/u Thumb, finger or sucking habits?
Until what age?________
☐Yes ☐ No ☐ dk/u Tongue thrusting?
☐Yes ☐ No ☐ dk/u History of speech problems
☐Yes ☐ No ☐ dk/u Mouth breathing, snoring or difficulty breathing?
☐Yes ☐ No ☐ dk/u Tooth grinding or clenching of the jaw?
☐Yes ☐ No ☐ dk/u Ringing of the ears?
☐Yes ☐ No ☐ dk/u Any clicking, popping of your jaw joint?
☐Yes ☐No ☐dk/u Any pain or sorenss of the muscles of the face or around the ears?
☐Yes ☐ No ☐ dk/u Difficulty chewing or jaw opening/closing?
☐Yes ☐ No ☐ dk/u Had serious problems with previous treatment?
☐Yes ☐ No ☐ dk/u Treatment for "TMD" or "TMJ"
☐Yes ☐ No ☐ dk/u Loose, broken, or missing fillings
☐Yes ☐ No ☐ dk/u Irritations of the tongue, cheek, lip, or palate
☐Yes ☐ No ☐ dk/u Problems with wisdom teeth?
☐Yes ☐ No ☐ dk/u Periodontal (gum) treatment?
☐Yes ☐ No ☐ dk/u Overdeveloped/Underdeveloped jaw?
☐Yes ☐ No ☐ dk/u Relatives with similar jaw problems?
☐Yes ☐ No ☐ dk/u Had previous orthodontic treatment?
☐Yes ☐ No ☐ dk/u Are you currently in treatment?

Previous Doctors Name ____
Previous Doctors Address ______________________________________
____

Please describe:

How often do you brush? ____________________________________
How often do you floss? ____________________________________

What are your primary concerns?

CONSENT:
I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent. I have thoroughly reviewed my health history. My signature below verifies that all of the necessary changes have been made.

Patient Signature ____ Date:______________________________
Dentist's Signature ____ Date:______________________________

Dental History