



**HIGGINBOTTOM**  
 — ORTHODONTICS —  
 SMILE WITH STYLE

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**ADULT REGISTRATION**

Patient Name		Nickname	Soc. Sec. #
Street Address			Birthdate
City	State		Zip
Home Phone	Business Phone	Marital Status	
Cell Phone	Email		
Patient's Employer			Occupation
Employer Address			Business Phone
Spouse's Name	Birthdate	Soc. Sec. #	

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please check YES or NO (If YES, please fill out details)

YES  NO Are you taking any medications? \_\_\_\_\_

YES  NO Are you taking any medications for osteoporosis (example-Fosamax or Actonel) \_\_\_\_\_

YES  NO Are you allergic to any medication? \_\_\_\_\_

YES  NO Do you have a history of a major illness? \_\_\_\_\_

YES  NO Have you had any operations? \_\_\_\_\_

YES  NO Have you ever been involved in a serious injury? \_\_\_\_\_

YES  NO Have you seen a physician in the last 12 months? Why? \_\_\_\_\_

YES  NO Has the patient been ill for more than 5 days in the last 12 months? Name the illness: \_\_\_\_\_

Please check any of the medical conditions below that you have had or currently have:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding/Hemophilia | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Asthma or Hayfever           | <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Allergies                    | <input type="checkbox"/> Gastrointestinal Disorder | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Tumor or Cancer        |

Patient name: \_\_\_\_\_

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Back & Neck Pain          | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Pneumonia          |
| <input type="checkbox"/> Congenital Heart Defect   | <input type="checkbox"/> Hepatitis/Liver Problems | <input type="checkbox"/> Prolonged Bleeding |

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

### DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

- Yes  No Are you concerned about the appearance of your teeth? \_\_\_\_\_
- Yes  No Do you have difficulty in chewing or swallowing your food? \_\_\_\_\_
- Yes  No Have any of your teeth been removed by a dentist/oral surgeon? \_\_\_\_\_
- Yes  No Have you ever lost or chipped any teeth? \_\_\_\_\_
- Yes  No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_
- Yes  No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_
- Yes  No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_
- Yes  No Do you have any type of thumb, finger or tongue habit? \_\_\_\_\_ Age when stopped \_\_\_\_\_
- Yes  No Are you a mouth breather? \_\_\_\_\_
- Yes  No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes  No Has anyone in your family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_
- Yes  No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_
- Yes  No Are you aware of your jaw clicking or popping? \_\_\_\_\_
- Yes  No Are you aware of clenching your teeth during the day? \_\_\_\_\_
- Yes  No Have you ever been told that you grind your teeth? \_\_\_\_\_
- Yes  No Do you bite your lips, tongue, fingernails, pencils or other objects? \_\_\_\_\_
- Yes  No Do you have "tension" headaches? \_\_\_\_\_
- Yes  No Have you ever experienced chronic ringing in the ears? \_\_\_\_\_
- Yes  No Do you have sleep apnea or do you snore? \_\_\_\_\_
- Yes  No Have you had your tonsils or adenoids removed? \_\_\_\_\_
- Yes  No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_
- Yes  No Does any member of your family or close relatives have a similar arrangement of teeth or a similar appearance in jaws? \_\_\_\_\_
- Yes  No Do you brush your teeth in the morning? \_\_\_\_\_
- Yes  No after lunch? \_\_\_\_\_
- Yes  No after dinner? \_\_\_\_\_
- Yes  No before bed? \_\_\_\_\_
- Yes  No Do your gums bleed when you brush? \_\_\_\_\_

**FEMALE PATIENTS ONLY:**

- Yes  No Are you pregnant? \_\_\_\_\_

If any of your relatives have been seen in this office, please list their names: \_\_\_\_\_

What is your reason for seeking orthodontic treatment? \_\_\_\_\_

What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_

Patient name: \_\_\_\_\_

How did you learn about our office? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Please list some hobbies or interests \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of his team responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_