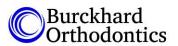


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Adult Patient Registration

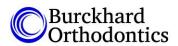
Today's date://		
Patient name:	Nickname:	Gender:
Date of birth:/ Age:		
Home phone: ()	Work phone: ()	
Cell phone: ()	Email address:	
Patient's address:	City:S	tate:Zip:
	Date of last cleaning and	
	Clinic:	
	ur office:	
Interests and hobbies:		
Spouse's name:		
	Relationsh	in·
		·P•
	Date of	
	Work phone: ()	
	Email address:	
	City:S	
	Occupation:	
]	Dental insurance information	
***If you do have dental insurance, please Orthodontic coverage: Yes No Lifetime	bring the card to your appointment. e maximum of coverage \$ (if known):	
Primary insurance co. name:	Subscriber name	e:
	p#Effective date of cov	
	City:	
Phone number: ()	<u> •</u>	
Secondary insurance co. name:	Subscriber name	<u>. </u>
ID# Cron	p # Effective date of cov	
		_
	S	tate 7in.



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Medical history

N	Are you in good health?	If no, explain:			
N	Do you have any history of major illness?				
N	Are you allergic to any medications/foods/other?				
N	Are you currently taking any medications?				
N	Are you currently taking any medications to reduce bone loss?				
N		<u>-</u>			
N		n: cation such as antibiotics for dental visits			
		ication for pre-medication:			
N	Abnormal bleeding	Y N Depression	Y N Hospital stays/surgeries		
	AIDS / HIV positive	Y N Diabetes	Y N Kidney problems		
	ADHD / ADD	Y N Disabilities	Y N Liver problems		
	Anemia	Y N Drug or alcohol dependence	<u>-</u>		
	Anxiety	Y N Epilepsy/seizures	Y N Osteoporosis/Osteopenia		
	Arthritis	Y N Hearing problems	Y N Rheumatic fever		
	Asthma	Y N Heart attack	Y N Speech problems		
	Autism	Y N Heart disease	Y N Sickle cell anemia		
	Breathing problems	Y N Heart murmur	Y N Stroke		
	Cancer	Y N Hemophilia Type			
	Cerebral palsy	Y N Hepatitis Type			
	Cleft lip/palate	Y N High blood pressure	If yes, what		
	T.T.	, , , , , , , , , , , , , , , , , , ,	If yes, how much		
ma	les only				
	Pregnant				
- 1	110gmunt				
yes	to any of the above, please	explain:			
ny c	other medical conditions: _				



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Dental history

Why did you come to Burckhard Orthodontics:		
v	NI	Do you want orthodontic care?
1	14	Do you prefer: Braces Clear Aligners (Invisalign®, 3M TM Clarity TM) Open to either option
Y	N	Have you had any injuries to the face, mouth, teeth, or chin:
		Have you had a recent panoramic x-ray or full-mouth set of x-rays taken? If so, where:
Y	N	Has an orthodontist been consulted previously?
		If yes, who did you see and date of consultation:
Y	N	Have you been informed of any missing permanent teeth?
Y	N	Have you been informed of any extra permanent teeth?
Y	N	Any oral habits (such as nail biting, thumb sucking, finger sucking, lip sucking, lip biting)? If so, please explain:
Y	N	Clenching or grinding teeth
Y	N	Any clicking, popping, or jaw pain? If yes, please explain:
		Any family member(s) who have had braces?
		Have you had previous orthodontic treatment?
		If yes, where and when?
Aı	ıy o	ther dental conditions or issues:
co	nta	e truthfully answered all of the questions and agree to inform Burckhard Orthodontics of any changes in my ct information or medical/dental history. In addition, I authorize Burckhard Orthodontics to perform a lete orthodontic evaluation:
Si	gna	ture:Date:/