



## PATIENT REGISTRATION & MEDICAL HISTORY

Please answer ALL questions to the best of your knowledge. The information requested below is very important, since we treat the entire patient, and not just teeth. Please make it as complete and accurate as possible, as it will help us to provide the best possible health service. This information form becomes part of our permanent records and will be held in **strict confidence**. Please circle YES or NO when applicable. *Please provide us with any changes or updates in your medical history every 6 months.* Thank you.

### PERSONAL

Patient Name: \_\_\_\_\_

Nickname or Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Ethnic Background: (check all that apply, for diagnostic purposes only)

Filipino  Caucasian

African American  Hispanic

Asian (please specify): \_\_\_\_\_

Other: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Gender:  Male  Female

### BILLING PARTY

(Complete only if different from patient)

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Mobile Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

### SOCIAL

1. Occupation: \_\_\_\_\_

2. Marital status:  Single  Married

3. Do you smoke? YES NO

Have you ever smoked? YES NO

If yes, to either of the above, for how long? \_\_\_\_\_

How many cigarettes per day? \_\_\_\_\_

4. Do you drink alcoholic beverages? YES NO

If yes, how often? \_\_\_\_\_

### DENTAL

1. \*Please describe the orthodontic problem you would like to see corrected: \_\_\_\_\_

2. Does anyone in the family have a similar dental or facial condition? YES NO \_\_\_\_\_

3. Who referred you to our office? \_\_\_\_\_

4. Name of family dentist: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

5. Date of last dental appointment: \_\_\_\_\_

6. How frequently do you brush? \_\_\_\_\_

How frequently do you floss? \_\_\_\_\_

7. Have your teeth ever been injured? YES NO

Please describe: \_\_\_\_\_

8. Please check if you have or ever had any of the following habits:

Grinding

Lip biting or sucking

Nail biting

Thumb/finger sucking

Tongue thrusting

Mouth breathing

9. Please check if you have a history of the following:

Recurring canker sores, fever blisters, mouth ulcers, or oral herpes infections

Trouble with any previous dental treatments

Excessive bleeding after extraction, surgery or wounds

Difficulty chewing or swallowing

Pain, clicking, or locking of the jaws

Loose teeth

Sensitive teeth

Sore, bleeding gums

Frequent dry mouth

Other \_\_\_\_\_

10. Please rate your concern for correction of the orthodontic problem:

Very concerned  Concerned

Indifferent

Opposed

Uncertain

11. How do you think you will react to orthodontic treatment?

Excellent

Good

Fair

Poor

Uncertain

12. Have you ever had a consultation for orthodontic treatment before? YES NO

13. Have you ever had braces / orthodontic appliances before? YES NO If YES, when? \_\_\_\_\_

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**MEDICAL**

- Name of physician: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_
- Date of last physical exam: \_\_\_\_\_
- Have there been any changes in your general health within the past year? YES NO  
Please describe: \_\_\_\_\_
- Have you been hospitalized or had a serious illness within the past year? YES NO  
Please describe: \_\_\_\_\_
- Please check if you have experienced the following:
  - Surgery or radiation treatment for a tumor, growth or other condition in the mouth, neck or head
  - Chemotherapy
  - Loss or gain of 10 lbs or more within the past year
  - Swelling in the ankles
  - Dialysis treatment
- Please check if you are currently taking any of the following medications:
  - Antibiotics
  - Anticoagulants
  - Anticonvulsants
  - Antipsychotics
  - Bisphosphonates (Actonel, Boniva, Fosamax, Reclast, etc)
  - Cortisone, Other Steroids
  - Insulin
  - Birth control pills
  - Aspirin
  - Other: \_\_\_\_\_
- Is there a past history of taking any of the above medications? YES NO  
If yes, please describe: \_\_\_\_\_
- Please list any allergies (including latex and/or drug allergies): \_\_\_\_\_

**MEDICAL (cont'd)**

- Please check if you have had any unfavorable reactions to the following:
    - Local Anesthetics
    - Aspirin
    - Other: \_\_\_\_\_
    - Antibiotics
    - Sulfa Drugs
  - Do you require antibiotics before certain dental treatments? YES NO
  - Please check if you have a history of the following:
    - Anemia
    - Addictions to drugs/alcohol
    - Asthma / emphysema / breathing problems
    - Arthritis
    - Autism
    - Bone or joint problems
    - Brain injury
    - Cancer: \_\_\_\_\_
    - Cerebral palsy
    - Diabetes
    - Emotional difficulties
    - Epilepsy / seizures
    - Excessive bleeding
    - Fainting or dizziness
    - Hearing difficulties
    - HIV+ / AIDS
    - Heart problems
    - Hepatitis / jaundice / liver disease
    - High blood pressure
    - Kidney disease
    - Mitral valve prolapse
    - Persistent cough / coughing blood
    - Psychiatric problems
    - Rheumatic fever or heart disease
    - Sexually transmitted disease
    - Sickle cell anemia
    - Speech difficulties
    - Stomach ulcer
    - Thyroid disease
    - Tuberculosis
    - OTHER: \_\_\_\_\_
  - Please check if there is a family history of the following:
    - Birth defects
    - Bleeding disorder
    - Cancer: \_\_\_\_\_
    - Diabetes
    - Heart disease
    - Hypertension
    - Kidney disease
    - Liver disease
    - Lupus
    - Obesity
    - Rheumatoid arthritis
    - Sickle cell anemia
    - Tuberculosis
    - Other: \_\_\_\_\_
- FEMALE PATIENTS ONLY:**
- Are you pregnant or anticipating a pregnancy in the near future? YES NO
  - Are you currently taking hormones? YES NO

**CONSENT STATEMENT**

Dr. Elaine V. Sunga and her staff are hereby authorized to perform such dental and related surgical or medical treatments as deemed necessary to adequately provide such treatment for the above named patient. The undersigned understands and agrees that each patient's records and materials pertinent to his/her treatment become property of Dr. Elaine V. Sunga – Orthodontics & Dentofacial Orthopedics. Dr. Elaine V. Sunga and staff are authorized to furnish, from the patient's record, requested information of pertinent nature or excerpts thereof, to any approximate insurance company for the purpose of obtaining payment of the account of the patient. By signing, I also give my permission for the use of orthodontic records made in the process of examinations, treatment, and retention for purposes of professional consultations, research, education, or publication in professional journals by Dr. Elaine V. Sunga.

***I have read the preceding information fully, and understand it, and agree to comply with all rules and regulations for patient processing and treatment. To the best of my knowledge, the preceding answers are complete and accurate.***

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY:**

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

**Health History Updates: (every 6 months while in active treatment)**

Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____	Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____
Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____	Any changes in the patient's health or medications? <input type="checkbox"/> Y <input type="checkbox"/> N Comments: _____ Signature: _____ Date: _____