# Welcome to our office

## Ernest H. McDowell, D.M. D.

McDowell Orthodontics

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Member American Association of Orthodontists

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## NEW PATIENT REGISTRATION FORM

***(FOR PATIENTS OVER AGE 18)***

The information provided is strictly confidential

Please Print Legibly

## PATIENT INFORMATION

Today's Date: _____

### ABOUT YOU

Name:_____
Last First MI

I prefer to be called:_____ ___Male___Female
Birthdate:___/___/_____ Age:_____ SS#:_____
Home Address:_____
_____
City State ZIP

E-Mail Address:_____

**Marital Status**
___Single___Married___Divorced___Widowed___Separated

Home #: (___)_____
Cell #: (___)_____
**Work #:** (___)_____ Ext.:_____
**Driver's License #:**_____
Employer:_____
Employer's Address:_____
_____
How long there?_____
Occupation:_____
Where & when are the best times to reach you?
_____
Whom may we thank for referring you?
_____
Other family members seen by us:_____
_____
_____

General Dentist:_____

Last Visit Date:_____

### SPOUSE INFORMATION

His/Her Name:_____

Birthdate:___/___/_____Age:_____SS#:_____
Employer:_____
Work #:_____Ext.:_____

### ORTHODONTIC INSURANCE

**PRIMARY**

Orthodontic Coverage:__Yes__No Dental Coverage:__Yes__No
Ins. Co. Name:_____
Ins. Co. Address:_____
Ins. Co. Phone: (___)_____
Group # (Plan, Local, or Policy #):_____
Insured's Name:_____ Relation:_____
Insured's D.O.B.:___/___/_____Insured's ID #:_____
Insured's Employer:_____

**SECONDARY**

Orthodontic Coverage:__Yes__No Dental Coverage:__Yes__No
Ins. Co. Name:_____
Ins. Co. Address:_____
Ins. Co. Phone: (___)_____
Group # (Plan, Local, or Policy #):_____
Insured's Name:_____ Relation:_____
Insured's D.O.B.:___/___/_____Insured's ID #:_____
Insured's Employer:_____

### PERSON RESPONSIBLE FOR ACCOUNT

Name:_____
Best Contact #:_____
Billing Address:_____
Relation:_____

### EMERGENCY CONTACT

Name:_____
Best Contact #:_____
Relation:_____

## MEDICAL HISTORY

**Your current health is:** ___ Good ___Fair ___Poor
Do you have a personal physician? ___Yes ___No
Physician's Name:_____
Phone #: (___)_____Date of last visit:_____
Are you currently under the care of a physician? ___Yes ___No
Please explain:_____
Are you taking any prescription/over-the-counter drugs? ___Yes ___No
Please list each one:_____
For Women:
Are you using a prescribed method of birth control? ___Yes ___No
Are you pregnant? ___Yes ___No Week #:_____
Are you nursing? ___Yes ___No

### Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N Anemia
Y N Artificial Bones/Joints/Valves
Y N Asthma/Arthritis
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Diabetes
Y N Difficulty Breathing/Snoring
Y N Drug/Alcohol Abuse
Y N Emphysema
Y N Epilepsy/Seizures/Fainting
Y N Glaucoma
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)
Y N Ulcers
Y N Colitis
Y N Venereal Disease

**Please list any serious medical conditions you have ever had:**

_____

### Are you allergic to any of the following?

Y N Aspirin
Y N Any Metals/Plastics
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other
Please list any other drugs/materials you are allergic to:_____
_____

## DENTAL HISTORY

What are the main concerns that you would like orthodontics to accomplish?_____
_____
Have you ever had or been evaluated for orthodontic treatment?__Yes__No
Have you ever had a serious/difficult problem associated with any previous dental work? ___Yes ___No
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ___Yes ___No
**Your current dental health is:** ___Good ___Fair___Poor
Do you like your smile? ___Yes ___No
Do your gums ever bleed? ___Yes ___No
Have you ever had an injury to your: ___Mouth___Teeth___Chin
Do you have any speech problems?_____
Do you generally breathe through your mouth? ___Yes ___No
If yes, please circle: While Awake? While Asleep?
Do you have any missing or extra permanent teeth? ___Yes ___No
Have you ever taken Fosamax, or any other bisphosphonate?__Yes __No
Have you ever taken Phen-Fen? ___Yes ___No
Do you smoke or use tobacco in any form? ___Yes ___No

### SLEEP BEHAVIOR

Do you frequently snore? ___Yes ___No
Do you frequently grind your teeth during sleep? ___Yes ___No
Do you seem tired during the daytime? ___Yes ___No

### BOTOX & DERMAL FILLERS

Are you interested in Botox or Dermal Fillers? ___Yes ___No
Have you ever had Botox and/or Dermal Fillers? ___Yes ___No
If yes, please explain: _____
_____
Do you have frequent migraine/muscle headaches? ___Yes ___No

### INFORMATION & 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.

_____
Signature Date

### CONSENT TO THE USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, publication in professional journals, scientific papers, demonstration or marketing purposes. In addition, when i-CAT images are taken, Dr. McDowell will interpret only those areas consistent with a 2D panorex or ceph. The patient is welcome to have these images further diagnosed by a radiologist for more details at their cost.

_____
Signature Date

**THANK YOU FOR FILLING OUT THIS FORM COMPLETELY**

**Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA**

### OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian of the patient named herein. Initials:_____Date:_____

Doctor's Comments:_____