Patient Registration Form

Today's Date_____

Referred by: dentist name? _____ Website? _____

friend name? _____ Other? _____

Patient's Name: First_____ Last _____Middle Initial____

Date of Birth _____ Age_____ Gender _____
M / D / Y

Primary Contact Person's Name (for patients who are minors only)_____

Home Address_____

City_____ Postal Code_____

Land Line _____ Cell Phone_____

Primary Email contact _____

Physician's Name and Location _____
_____

Dentist's Name and Location _____
_____

Have any other family members seen Dr. Taylor, Dr. Shamloo or Dr. Huang? no __ yes __

If yes, name(s) _____

Information for patients who are MINORS:

	Father	Mother
Name..(first and last).....	_____	_____
Home address.....	_____	_____
(if different from above)	_____	_____
Land line (if different from above)	_____	_____
Business phone	_____	_____
Cellular phone	_____	_____
Employer	_____	_____
Ortho insurance coverage?	Yes ___No ___	Yes ___No ___

Information for ADULT patients:

	Patient	Spouse
Name ..(first and last).....	_____	_____
Business phone.....	_____	_____
Cellular phone.....	_____	_____
Employer.....	_____	_____
Ortho coverage for adults?	Yes ___No ___	Yes ___No ___

Medical History

Is the patient experiencing any health problems? _____
Currently under physician's care? Reason? _____
Currently taking medication? List? _____
Allergies? List? _____
Drug Sensitivity? List? _____
Has the patient ever received a blood transfusion? _____
Has the patient ever been hospitalized? _____
Does the patient have any birth defects or disabilities? _____
Has the patient ever had an injury to the mouth or teeth? _____

Has patient had any of the following:

Anemia	YES	NO	Bleeding disorders	YES	NO
Hepatitis	YES	NO	Rheumatic Fever	YES	NO
Heart murmur	YES	NO	Heart disease	YES	NO
Tuberculosis	YES	NO	Diabetes	YES	NO
Hormone problems	YES	NO	Bone disorders	YES	NO
Epilepsy	YES	NO	Head injuries	YES	NO
Speech problems	YES	NO	Frequent colds	YES	NO
Asthma	YES	NO			

Mouthbreathing: YES NO

Snoring: YES NO

Wake up tired in the morning? YES NO

Tonsils (Adenoids) PRESENT REMOVED

DENTAL HISTORY

Is there a history of thumb sucking?	**YES**	**NO**
Is the thumb or finger sucking still present?	**YES**	**NO**

At what age did finger or thumb sucking stop_____
Frequency of dental check-ups_____
Consulted an orthodontist previously?_____
Had previous orthodontic treatment? _____

Is there a HISTORY of:

Clenching teeth.....…	YES	NO
Grinding Teeth.....…	YES	NO
Muscular soreness around head and neck.....……..	YES	NO
Headaches (more than normal).....…..	YES	NO
Jaw joint soreness.....	YES	NO
Jaw joint clicking.....…	YES	NO
Ringing in the ears.....	YES	NO

Why are you seeking orthodontic consultation? _____

_____

Signed_____**Date**_____