TAYLOR & MURRAY ORTHODONTICS
ADULT ORTHODONTIC REGISTRATION FORM

Date_____

PATIENT INFORMATION

Last Name_____ First Name_____ Middle Initial____ Sex___

How would you like us to address you? _____ Date of Birth____ / ____ / ____ Age_____

Home Address_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

Email Address_____

Employed By_____ Occupation_____

Business Address_____ Bus. Phone_____

Marital Status (Please circle) Single Married Widowed Separated Divorced

Spouse's Name_____ Occupation_____

Employed By _____ Bus. Phone_____

Person Responsible for Account_____

Do you have Orthodontic insurance? (Please circle) YES NO UNSURE

If Yes, Name of Company_____ Phone Number _____

Policy Holder's Name_____ Policy Holder's S.S. # _____ - _____ - _____

ID# _____ Group # _____

Whom may we thank for referring you? _____

What is your primary reason for seeking orthodontic treatment? _____

MEDICAL INFORMATION

Name of Physician_____

Are you under the care of a physician at this time? Yes No
Explain_____

Taking any medication? Yes No
If yes, please list_____

Any allergies or sensitivity (drug, metal, jewelry, latex)? Yes No
If yes, please list_____

Have tonsils and/or adenoids been removed? Yes No

Frequent colds, sore throat, or ear infections? Yes No

(Women) Is the patient pregnant? Yes No

Have you ever been advised by your physician to take an antibiotic prior to any dental treatments? Yes No
If yes, antibiotic name and method_____

Please circle any conditions that you have now or have ever been treated for

Hepatitis	Rheumatic Fever	Emotional Problems	Fainting	HIV/AIDS	Diabetes
Asthma	Prolonged Bleeding	Convulsions	Arthritis	Epilepsy	Abnormal Blood Pressure
Brain Injury	Nervous Disorder	Kidney Problems	Heart Trouble	Heart Murmur	Endocrine Problems
Tuberculosis	Liver Problems	Other_____			

Any special problems or major illness not listed? Yes No
Explain_____

DENTAL INFORMATION

Name of Dentist_____ Date of Last Visit_____

Have there been any injuries to the face, mouth or teeth? Yes No
Explain_____

Have you ever had oral habits, such as lip biting, tongue thrusting, clenching or grinding? Yes No

Are you a mouth breather while asleep or awake? Yes No

Have you ever experienced jaw joint pain/discomfort (TMJ)? Yes No

Do you have any speech problems? Yes No

Has anyone in the family been previously treated in our practice? Yes No

Has an orthodontist been consulted previously? Yes No
If yes, Name_____ Date_____

Please rate the following on a scale from 1-10 (10 being the highest or best):

I think my current state of dental health is a:	1	2	3	4	5	6	7	8	9	10
The current appearance of my teeth is a:	1	2	3	4	5	6	7	8	9	10
The value I place on a beautiful smile is a:	1	2	3	4	5	6	7	8	9	10
My motivation for maintaining and improving my teeth is a:	1	2	3	4	5	6	7	8	9	10
The priority I am currently placing on my smile is a:	1	2	3	4	5	6	7	8	9	10

What prompted you to seek orthodontic treatment?_____

My reason for seeking treatment is: (Please circle all that apply) Esthetic Functional Health-Related

How would changing your smile affect your life?_____

I certify that I am covered by _____ Insurance Co. and I assign directly to Dr. Taylor all insurance benefits otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I herby authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature_____ Date_____