ADULT REGISTRATION

PATIENT NAME _____

LAST	FIRST	MIDDLE	NICKNAME	DATE
HOME ADDRESS		CITY	STATE	ZIP
HOME PHONE	BIRTHDATE	AGE SS#	MARITAL STATUS	SEX
WORK PHONE	EXT.	EMPLOYER	OCCUPATION	EMAIL

WHO MAY WE THANK FOR REFERRING YOU?_____

PRIME INSURED		SECONDARY INSURED	
SS#	D.O.B.	SS#	D.O.B.
EMPLOYER:		EMPLOYER:	
INS. CO.:		INS. CO.:	
INS. ADD.:		INS. ADD.:	
GROUP#/LOCAL:		GROUP#/LOCAL:	

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health and orthodontic treatment. I will review this history with you at the initial examination. Information you give me is strictly confidential and will not be released without your permission.

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST VISIT _____

ADDRESS (Street) _____ PHONE _____

CITY _____ STATE _____ ZIP _____

YES	NO	
❒	❒	HAVE YOU UNDERGONE A COMPLETE PHYSICAL DURING THE PAST YEAR?
❒	❒	ARE YOU PRESENTLY UNDER A PHYSICIAN'S CARE?
❒	❒	HAVE YOU HAD MAJOR SURGERY?
❒	❒	HAVE YOU EVER BEEN HOSPITALIZED?
❒	❒	ARE YOU TAKING ANY PILLS, MEDICATIONS OR DRUGS?
❒	❒	ARE YOU ALLERGIC TO NOVOCAINE OR PENICILLIN?
❒	❒	HAVE YOU HAD ANY UNUSUAL REACTION TO ANY MEDICATION?
❒	❒	HAVE YOU HAD TONSILS AND/OR ADENOIDS REMOVED?
❒	❒	DO YOU EVER HAVE FAINTING OR DIZZY SPELLS?
❒	❒	DO YOU HAVE A TOO HIGH OR LOW BLOOD PRESSURE?
❒	❒	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Yes	No		Yes	No	
❒	❒	HEART PROBLEMS	❒	❒	HEPATITIS/HIV
❒	❒	KIDNEY PROBLEMS	❒	❒	RHEUMATIC FEVER
❒	❒	LUNG PROBLEMS	❒	❒	EMOTIONAL PROBLEMS
❒	❒	LIVER PROBLEMS	❒	❒	MALIGNANCIES
❒	❒	ALLERGIES/LATEX	❒	❒	ENDOCRINE PROBLEMS
❒	❒	DIABETES	❒	❒	BONE DISORDER
❒	❒	EPILEPSY	❒	❒	PROLONGED BLEEDING
❒	❒	ARTHRITIS	❒	❒	TUBERCULOSIS
❒	❒	ANEMIA	❒	❒	ASTHMA

❒ ❒ ARE THERE ANY OTHER MEDICAL PROBLEMS NOT LISTED?

DENTAL HISTORY

DENTIST'S NAME _____ DATE OF LAST VISIT _____

ADDRESS (Street) _____ PHONE _____

CITY _____ STATE _____ ZIP _____

WHAT IS THE MAJOR CONCERN ABOUT THE PATIENT'S TEETH? _____

YES	NO	
❒	❒	HAVE YOU HAD PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT?
❒	❒	DO YOU HAVE ANY DIFFICULTY CHEWING OR SWALLOWING FOOD?
❒	❒	ARE YOU AWARE OF TOOTH GRINDING OR CLENCHING?
❒	❒	DO YOU HAVE A HEADACHE MORE THAN ONCE A WEEK?
❒	❒	HAVE YOU EVER HAD PAINS IN THE FACE OR HEAD?
❒	❒	ARE YOU EVER BOTHERED BY CHRONIC NECK PAINS?
❒	❒	HAVE YOU EVER HAD SEVERE JAW OR HEAD INJURY?
❒	❒	DO YOU EVER HAVE ANY PAIN OR CLICKING OF YOUR JAW JOINTS?
❒	❒	DO YOU HAVE ANY CHRONIC SORES INSIDE YOUR MOUTH?
❒	❒	HAVE YOU HAD ANY PERMANENT TEETH EXTRACTED?
❒	❒	DO YOUR GUMS BLEED ON BRUSHING OR FLOSSING?
❒	❒	HAVE YOU EVER BEEN TREATED FOR GUM DISEASE?
❒	❒	HAVE YOU HAD ANY PREVIOUS UNPLEASANT DENTAL OR ORTHODONTIC EXPERIENCES?
		HOW MANY TIMES A WEEK DO YOU USE DENTAL FLOSS ?_____
❒	❒	ARE THERE ANY OTHER DENTAL/ORTHODONTIC PROBLEMS I SHOULD BE AWARE OF?

ADDITIONAL INFORMATION OR COMMENTS: _____

I acknowledge I have received from the office of Dr. Andrew Kouvaris, a copy of the Notice of Privacy Practices.

YOUR SIGNATURE: _____ DATE _____

ANDREW S. KOUVARIS, DDS, MSD