



Glades Road Medical Center
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Quality Affordable Orthodontic Care

WELCOME. We are pleased to welcome you to our practice...TEAM OTA. Please take a few moments to fill out this form as thoroughly as possible. If you have questions, we'll be glad to assist you.

REGISTRATION INFORMATION

Patient's Name First _____ Middle _____ Last _____ Social Security # _____
 Date of Birth _____ Age Years _____ Months _____ Sex: Male Female
 Home Address Street _____ City _____ State _____ Zip Code _____
 Home Phone (____) _____ Cell Phone (____) _____ Email _____
 Patient Is: Single Married Divorced Remarried Widowed A Minor Adopted
 Whom may we thank for referring you to our office? _____
 Emergency Contact: Name First _____ Middle _____ Last _____ Phone (____) _____
(Relative Not Living With You)
 Address Street _____ City _____ State _____ Zip Code _____

IF PATIENT IS A MINOR

Father's Information: Father Stepfather Guardian _____
 Name First _____ Middle _____ Last _____ Social Security # _____
 Home Address (If Different Than Above) Street _____ City _____ State _____ Zip Code _____
 Home Phone (____) _____ Cell Phone (____) _____
 Occupation _____ Employer _____ How Long? _____
 Work Address Street _____ City _____ State _____ Zip Code _____ Work Phone (____) _____

Mother's Information: Mother Stepmother Guardian _____
 Name First _____ Middle _____ Last _____ Social Security # _____
 Home Address (If Different Than Above) Street _____ City _____ State _____ Zip Code _____
 Home Phone (____) _____ Cell Phone (____) _____
 Occupation _____ Employer _____ How Long? _____
 Work Address Street _____ City _____ State _____ Zip Code _____ Work Phone (____) _____

Familial Information:
 Parent's Marital Status: Married Divorced Separated Remarried Widowed Single
 Patient lives with: Both Parents Mother Father Guardian Other _____
 Names and ages of other children in family _____
 Patient's School _____ Current Grade _____
 List Musical Instruments Played _____ List Sports & Hobbies _____

IF PATIENT IS EMPLOYED

Occupation _____
 Employer _____ How Long? _____
 Work Address Street _____
City _____ State _____ Zip Code _____
 Work Phone (____) _____

IF PATIENT IS MARRIED

Spouse's Name First _____ Middle _____ Last _____
 Occupation _____ Social Security # _____
 Employer _____ How Long? _____
 Work Address Street _____ City _____
State _____ Zip Code _____ Work Phone (____) _____

RESPONSIBLE PARTY / INSURANCE INFORMATION

Person Responsible for Account First _____ Last _____ Relationship to Patient _____ Social Security # _____
 Home Address (If Different Than Patient's) Street _____ City _____ State _____ Zip Code _____ Home Phone (____) _____
 Insurance Company _____ Phone (____) _____
 Subscriber's Name First _____ Middle _____ Last _____ Contract # / Group # _____
 Employer (If Different Than Above) _____ Name _____ Phone (____) _____

DENTAL HISTORY

Dentist's Name First _____ Last _____ Date of Last Visit _____ Reason/Result _____
 Address Street _____ City _____ State _____ Zip Code _____ Phone (____) _____
 Is the patient in good dental health? Yes No If no, explain _____
 How often does the patient brush? _____ Floss? _____
 Has any other family member had orthodontic treatment? Yes No If yes, describe _____

DENTAL HISTORY - CONTINUED

Does the patient have, or has the patient had, any of the following conditions?

- Yes No Bleeding/tender gums
 Yes No Chewing/swallowing problems
 Yes No Clenching/grinding teeth
 Yes No Dental pain/toothaches
 Yes No Frequent canker/cold sores/fever blisters
 Yes No Injuries to face/head/neck/jaw/teeth
 Yes No Mouth breathing/snoring
 Yes No Periodontal (gums) evaluation/treatment
 Yes No Previous orthodontic examination/treatment
 Yes No Sinus problems/nasal obstruction
 Yes No Speech problems
 Yes No Supernumerary (extra)/congenitally missing teeth
 Yes No Teeth sensitive to hot/cold/sweet
 Yes No Tongue problems/thrusting (abnormal swallowing)

Does the patient have, or has the patient had, any of the following habits (chewing, biting or sucking)?

- Yes No Fingernails
 Yes No Ice
 Yes No Lips/cheeks/tongue
 Yes No Objects (pens, pencils, etc.)
 Yes No Thumb/fingers
 Yes No Other

Has the habit(s) stopped? Yes No If yes, list habit(s) and age stopped

Does the patient have, or has the patient had, any of the following concerns?

- Yes No Cosmetics
 Yes No Crooked teeth
 Yes No Overbite/underbite
 Yes No Protruding teeth
 Yes No Spaces
 Yes No Other

Does the patient have, or has the patient had, any of the following jaw problems?

- Yes No Clicking/popping
 Yes No Difficulty chewing/opening &/or closing mouth
 Yes No Pain (joint/ear/face)
 Yes No Ringing/buzzing in the ears
 Yes No Frequent headaches/earaches/neckaches
 Yes No Previous TMJ/TMD evaluation/treatment

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____ Reason/Result _____

Address _____ Phone (____) _____

Is the patient in good health? Yes No If no, explain _____

Is the patient currently being treated by a physician? Yes No If yes, explain _____

List all drugs or medications the patient is currently taking and the condition(s) being treated _____

Does your physician or cardiologist require you to take antibiotics prior to dental treatment? Yes No If yes, describe _____

Does the patient have, or has the patient had, any of the following conditions?

- Yes No Adenoids removed
 Yes No Alcohol/drug abuse
 Yes No Arthritis - type
 Yes No Artificial joints/bones/prostheses
 Yes No Attention deficit disorder (ADD)/hyperactive/ADHD
 Yes No Birth defects/hereditary problems
 Yes No Blood disorders/bleeding problems/hemophilia/anemia/ sickle cell disease
 Yes No Bone disorders/osteoporosis
 Yes No Cancer/tumors/chemotherapy/radiation treatment
 Yes No Cerebral palsy
 Yes No Chicken pox
 Yes No Circulatory problems
 Yes No Congenital heart problems
 Yes No Cortisone/steroid treatment
 Yes No Depression
 Yes No Diabetes/hypoglycemia
 Yes No Dizziness/fainting
 Yes No Eating disorders/anorexia/bulimia
 Yes No Endocrine/thyroid/pituitary/hormonal problems
 Yes No Epilepsy/seizures/convulsions/neurological problems
 Yes No Handicaps/disabilities - type
 Yes No Hearing disorder
 Yes No Heart problems/attack/angina/murmur
 Yes No Heart surgery/pacemaker/bypass/artificial valves
 Yes No Herpes
 Yes No High/low blood pressure
 Yes No HIV positive/AIDS
 Yes No Hospitalized for any reason
 Yes No Immune/autoimmune problems
 Yes No Kidney problems
 Yes No Learning disorders/dyslexia
 Yes No Liver problems/jaundice/hepatitis - type
 Yes No Lung/breathing problems/asthma/emphysema/pneumonia
 Yes No Lupus
 Yes No Measles
 Yes No Mitral valve prolapse
 Yes No Mononucleosis
 Yes No Mumps
 Yes No Parkinson's disease
 Yes No Psychiatric care
 Yes No Psychological/emotional problems/care
 Yes No Rheumatic fever/heart disease
 Yes No Scarlet fever
 Yes No Scoliosis/spine problems
 Yes No Sexually transmitted disease - type
 Yes No Shingles
 Yes No Sleep disorders/apnea
 Yes No Stomach/intestinal problems/ulcers/colitis/IBS
 Yes No Stroke
 Yes No Tobacco/smoking/chewing/snuff habit
 Yes No Tonsillitis/tonsils removed
 Yes No Tuberculosis (TB)
 Yes No Typhoid fever
 Yes No Visual problems/glaucoma
Females:
 Yes No Is the patient pregnant? If yes, due date
 Yes No Is the patient anticipating pregnancy?
 Yes No Has the patient started menopause? If yes, age
Females/Growth Information:
 Yes No Has the patient's menstrual cycle started? If yes, age
 Yes No Has the patient had a growth spurt? If yes, age
Other signs of pubertal development
Males/Growth Information:
 Yes No Has the patient's voice changed? If yes, age
 Yes No Has the patient started to shave? If yes, age
 Yes No Has the patient had a growth spurt? If yes, age
Other signs of pubertal development

Does the patient have, or has the patient had, an allergic reaction to any of the following?

- Yes No Local anesthetics (Novocaine/Lidocaine)
 Yes No Aspirin/ibuprofen (Advil/Motrin)
 Yes No Penicillin/erythromycin/other antibiotics
 Yes No Sulfa drugs
 Yes No Codeine/other narcotics
 Yes No Drugs/medications - list
 Yes No Latex/vinyl (gloves/balloons)
 Yes No Metals (jewelry/nickel/mercury)
 Yes No Acrylic
 Yes No Animals
 Yes No Foods
 Yes No Other - list

EXPLANATIONS/COMMENTS

Please explain any 'yes' answers and/or other comments. Additionally, is there any other medical and/or dental information that you feel we should know? (i.e. other serious illnesses, medical/dental problems, drugs/medications taken but not listed above on this form, etc.).

AUTHORIZATION

I hereby certify that the above information is complete and accurate to the best of my knowledge. I understand that this information will be used to help determine an appropriate diagnosis and treatment plan, and I agree to immediately notify Dr. Cohen/OTA of any changes in the patient's health status.

Individual Completing This Form/Relationship to Patient

Signature

Today's Date

TEAM OTA is proud to be HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.