IOWA CITY ORTHODONTICS

New Patient Registration Form-Adult

Date_____

Patient Name_____ Sex_____ Birthdate_____

Preferred Name_____

Address_____ Home Phone #_____

City_____ State_____ Zip Code_____

Work #_____ Cell #_____

With which phone number do you prefer to be contacted?_____

Do you have orthodontic insurance?_____ Company_____

Policy Holder Name_____ DOB_____ Policy ID #_____

Who is your regular dentist_____ Did they refer you here?_____

Date of Last Dental Exam_____

Whom may we thank for referring you to our office?_____

Why are you are seeking orthodontic treatment?_____

Have you been or are you currently treated for any medical/psychological issues? (please list)_____

_____

Are you taking any medications? (please list)_____

Have you had any injuries or operations involving the head, neck, or teeth?_____

Please explain_____

Are you allergic to anything (please list)_____

Do you have a sensitivity to latex gloves?_____

Have you ever had pain/clicking/tenderness of the jaw joint (TMD/TMJ)_____

Have you been informed of any missing or extra permanent teeth?_____

Do you have a have a history of (Y/N):

Clenching/grinding teeth_____ Lip sucking/biting_____

Thumb/finger sucking_____ Tongue thrust_____

It is important that the above information is correct and complete. It will be held in the strictest of confidence and used only for in-office treatment and paperwork. Your permission will be required to share given information with any other party.