

RICK MARTIN, D.D.S. CERTIFIED BY THE AMERICAN BOARD OF ORTHODONTICS

PHONE: (225)925-9795 TEXT: (225)519-8595 FAX: (225)925-9791 www.RickMartinOrthodontics.com

ADULT REGISTRATION AND HEALTH HISTORY

PLEASE PRINT CLEARLY

Date _____

Last name _____ First name _____ Middle initial _____ Sex _____

Prefer to be called _____ Birth date _____ Spouse _____

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Occupation _____ Work Phone _____

Email address _____

Circle preference(s) for confirming your appointments: Text msg / Call cell / Call home / Call work / Email

Names and ages of children _____

Reason for seeking orthodontic treatment _____

Why did you select our office? _____

Person responsible for payment of this account _____

Address _____ City, State, Zip _____

Home phone _____ Cell phone _____ Work phone _____

Employed by _____ Social Security Number _____

Business address _____ City, State, Zip _____

Name of general dentist _____ Date of last dental exam _____

Are you being treated by a physician for a medical problem currently? _____

Have you ever had any major illnesses? _____ Have you ever been hospitalized for any reason? _____

Please explain any positive responses _____

Have you ever had any of the following? (Please check if yes)

Diabetes _____	Ear infections _____	Heart trouble _____
Glaucoma _____	Blood disorders _____	Venereal disease _____
Arthritis _____	Kidney problems _____	Rheumatic fever _____
Tumors _____	Bone disorders _____	Bleeding problems _____
Rickets _____	Fainting or dizziness _____	Tuberculosis _____
Hepatitis _____	Aids related complex _____	Nervous disorders _____
Epilepsy _____	Frequent headaches _____	Liver problems _____
Asthma _____	Sickle cell anemia _____	Sinus problems _____

List all drugs and medications you are **ALLERGIC** to: _____

List all drugs and medications you are currently **TAKING**: _____

Height _____ Weight _____ Women, are you pregnant? _____ When due _____

I certify that the above statements are correct (Signature) _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I authorize Dr. Martin to furnish information to insurance carriers concerning treatment for me or my dependents, and I hereby assign to Dr. Martin all payments for orthodontic services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____

Signature _____