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

PHONE (225) 925-9795 FAX (225) 925-9791 www.RickMartinOrthodontics.com

ADULT REGISTRATION AND HEALTH HISTORY

PLEASE PRINT CLEARLY Date_____

Full Name_____ Nickname_____ Phone_____

Address_____ City_____ Zip_____

Birth date_____ Sex_____ Marital Status_____Spouse_____

Occupation_____ Favorite Pastime_____

Names and ages of children_____

Who referred you to this clinic?_____

Name of dental insurance carrier, if any_____

Person responsible for payment of this account_____

Address_____ City_____ State_____ Zip_____

Employed by_____ Social Security Number_____

Business address_____ City_____ State_____ Zip_____

Home phone_____ Business phone_____ Other phone_____

Reason for seeking orthodontic treatment_____

Name of general dentist_____ Date of last dental exam_____

Name of physician_____ Date of last medical 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	_____

Have your tonsils and/or adenoids been removed?_____ If so, when?_____

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**_____