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

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# ORTHODONTIC REGISTRATION AND HEALTH HISTORY

**PLEASE PRINT CLEARLY** Date________________

Full Name____________________________ Nickname_________________ Phone________________

Address___________________________________ City_____________________ Zip______________

Birth date________________ Sex_____________ School___________________________ Grade_____

Father's name_________________ Mother's name________________ Favorite Pastime_____________

Names and ages of other children in family__________________________________________________

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?__________________________

Have you reached puberty?________ (Boys voice changing, girls menstruating)

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**____________________________________________