Welcome Form

Adult Patient Registration

Date: ______________________

Your Full Name: ____

By what name would you like to be called? ____

Address: ____ City: _______________________ State: ______ Zip: ________

Phone: ________________________________ Email Address____

Birth Date: __________________________ SSN: ____________________________ Marital Status: _________________

Whom should we thank for referring you to our office? ____

Name of your general Dentist: ____ Last Visit: ________________________

Has anyone in your family been treated in this office? ____

How would you like appointment confirmations? Email Text Both

Are you on Facebook? Y N Please join us @ www.facebook.com/howardortho

Your Employer	**Your Spouse**
Employer Name: ________________________________	Name: ____
Address: ____	Employer Name: __________________________________
Occupation: _____________________________________	Occupation: _____________________________________
Business Phone: _________________________________	Business Phone: __________________________________
Cell Phone: _____________________________________	Cell Phone: ______________________________________
Mobile Carrier:___________________________________	Mobile Carrier:____________________________________

Lisa P. Howard DDS, MS

207-885-1005
306 U.S. Route 1
Building D, Suite 1
Scarborough, ME 04074

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Welcome Form

Adult Dental History

Please help us to understand your dental condition and experiences by answering the following questions:

Have you ever had:

Y N Abscessed or extracted teeth?

Y N Injured or chipped teeth?

Y N Any severe head injuries?

Y N Sore or bleeding gums?

Y N Any jaw noise or pain?

Y N Limited opening of the jaw?

Y N Numbness or tingling of the face?

Y N Previous orthodontic treatment?

Y N Was the correction completed?

Y N Any problem with prior dental work?

Do You:

Y N Have any speech problems?

Y N Have any TMJ discomfort?

Y N Breath predominately through your mouth?

Y N Clench or grind your teeth?

Y N Have missing permanent teeth?

Y N Have extra permanent teeth?

Y N Do any family members have a similar condition?

Have You:

Y N Been happy with the appearance of your teeth?

Y N Has any member of your family had orthodontic treatment?

Y N Have you had an orthodontic evaluation before? If so, how long ago: ____

What treatment was recommended at that time? ____

Who first suggested the need for orthodontic treatment? ____

What would you like orthodontics to accomplish? ____

____

____

What concerns do you have regarding orthodontic treatment for yourself at this time? _______________________________

____

____

Please circle all that apply: Appearance Cost Quality Discomfort Function Time

Welcome Form

LISA P. HOWARD DDS, MS
Orthodontic Specialist

Adult Medical Health History

Circle how you rate your current overall health: Excellent Good Fair Poor

Y N Have you ever been hospitalized? If so, for what: ______________________________

Y N Are you ***allergic*** to any drug or other substances? If so, what: ______________________________

Y N Are you ***allergic*** to Latex?

Y N Have you ever experienced bleeding that was hard to stop?

Please list any medications you are currently taking: ______________________________

____

Y N Do you smoke? How much? ______________________________ Do you want to quit? N Y

Please Circle All Conditions That Apply To You

Heart murmur	Hives/Rash	Hay fever
Heart surgery	TMJ problems	Epilepsy
Rheumatic/Scarlet fever	Frequent headaches	Fainting
Heart pacemaker	Depression	AIDS/HIV
Artificial heart valve	Thyroid disorder	Emotional problems/issues
Artificial joints	Sinus trouble	Diabetes
High/Low blood pressure	Hepatitis	Nervous/Anxious
Shortness of breath	Asthma	Immune system disorders
Chest pains	Tuberculosis	STD
Tactile defensive	Bronchitis	Anti-osteoporosis meds

Females: Are you pregnant? Yes No

Is there any condition or problem or other information that you think would be helpful for us to know?

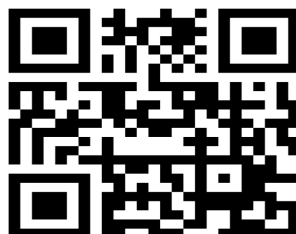
____

____

____

______________________________ ______________________________

Patient's Signature Today's Date



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