Welcome Form

Adult Patient Registration

SOUTHERN MAINE ORTHODONTICS
LISA P. HOWARD, D.D.S., M.S.
CHRISTOPHER A. MURPHY, D.M.D., M.D.S.

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/southernmaineorthodontics

Your Employer	Your Spouse
Employer Name: _____	Name: _____
Address: _____	Employer Name: _____
Occupation: _____	Occupation: _____
Business Phone: _____	Business Phone: _____
Cell Phone: _____	Cell Phone: _____
Mobile Carrier:_____	Mobile Carrier:_____

Southern Maine Orthodontics

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

www.southernmainebraces.com
www.facebook.com/southernmaineorthodontics

Welcome Form

Adult Dental History

SOUTHERN MAINE ORTHODONTICS

LISA P. HOWARD, D.D.S., M.S.

CHRISTOPHER A. MURPHY, D.M.D., M.D.S.

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

Adult Medical Health History

SOUTHERN MAINE ORTHODONTICS

LISA P. HOWARD, D.D.S., M.S.

CHRISTOPHER A. MURPHY, D.M.D., M.D.S.

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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