ADULT PATIENT REGISTRATION

TODAY'S DATE:

Bertha Dieguez-Marino, D.M.D., M.P.H.
Specialist in Orthodontics for Children & Adults

Full Name: Nickname DL#:
Male/Female (Circle) Birthdate: Age: SS #:
Marital Status: Single Married Widowed Divorced Separated
Home Address: City: State: Zip:
Home #: Cell#: Work#: Other#:
Employer: Occupation: How long there?
Employer's address: City: State: Zip:
When and where are the best times to reach you?
What is the best way to contact you regarding appointments? E-mail Phone
E-mail address(s):

Whom may we thank for your referral? Phonebook Insurance Co Dentist Friend
Website If Internet, what did you Google? Other

Name of Spouse/closest relative Relation to You (if not spouse)
Home Address: City: State: Zip:
Home#: Cell#: Work#: Other#:

Person(s) Financially Responsible for Acct:
Name(s): Relation to patient:
Billing Address:
City: State: Zip: SS #: DL #:
E-Mail: Home #: Cell/Other #:
Employer: Work #: Ext:

Insurance Information:	**Primary:**	**Secondary:**
Ins. Co. Name:		
Phone #:		
Ins. Co. Address:		
Insured's Name:		
Relationship to Patient:		
Insured's Birthday & SS#		
Insured's Employer:		
Effective Date:		
Contract # / Group #		
Lifetime Max:	Payable @ %:	Payable@%:
Age Limit / Waiting Period		

DENTAL HISTORY:

Dentist Name Last Visit For what service?

Your current dental health is Good Fair Poor

Now or in the past have had:

Permanent or "extra" teeth removed ?	Y/N	Chipped or injured baby or permanent teeth?	Y/N
"Extra" or congenitally missing teeth ?	Y/N	Teeth sensitive to hot or cold; teeth throb or ache?	Y/N
Bleeding gums, bad taste or mouth odor problems ?	Y/N	Ever had Peridontal / Root canal Treatment ?	Y/N
Frequent cancer sores or cold sores ?	Y/N	Any teeth irritating cheek, lip, tongue or palate ?	Y/N
Tooth grinding or jaw clenching problems ?	Y/N	Ever been treated for TMD or TMJ problems ?	Y/N
Mouth breathing habit, snoring or difficuly breathing ?	Y/N	Abnormal swallowing habit (tongue thrusting) ?	Y/N
Food impaction between teeth ?	Y/N	Finger, thumb, or other sucking habit ?	Y/N
History of speech problems ?	Y/N	Any serious trouble with previous dental work ?	Y/N
Aware or concerned about an under or over-developed jaw ?	Y/N	Any relative with similar tooth or jaw relationships ?	Y/N
Any jaw fractures, or other injuries to mouth or face ?	Y/N	Ever had a prior orthodontic examination or treatment ?	Y/N

What are the main concerns that you would like orthodontics to accomplish ?

MEDICAL HISTORY:

Your current physical health is Good Fair Poor

Are you currently under the care of a physician ? Y/N Please explain
Physician's Name: Phone: Date of last visit:

Are you taking any prescription / over-the-counter drugs ? If so, please list them:

Medication: Taken for:
Medication: Taken for:
Medication: Taken for:

Allergies or reactions to any of the following ?

Ibuprophen (Advil, Motrin), aspirin, acetaminophen (Tylenol), please specify
Penicillin, erythromycin, tetracycline, dental anesthetics, please specify
Plastics, acrylics, vinyls, metals, please specify
Other, please specify

Now or in the past, have you had: (please circle)

Drug / alcohol abuse / chewing or smoking tobacco ?	Y/N	Psychiatric / behavioral problems ?	Y/N
Bone fractures or any major accidents ?	Y/N	Artificial joints / plates / bones ?	Y/N
Hayfever, asthma, sinus trouble or hives ?	Y/N	Ear, nose, or throat conditions ?	Y/N
Thyroid/adenoid /tonsil condition ?	Y/N	Birth defects or hereditary problems ?	Y/N
Vision, hearing, tasting or speech difficulties ?	Y/N	History of eating disorder (anorexia, bulimia) ?	Y/N
Abnormal bleeding (hemophilia) or bruising tendency ?	Y/N	Ulcers / colitis / anemia / tires easily ?	Y/N
Hepatitis, jaundice or liver problems ?	Y/N	Kidney problems ?	Y/N
Endocrine or Thyroid problems ?	Y/N	Diabetes ?	Y/N
Epilepsy, seizures, fainting spells or neurological problems ?	Y/N	Severe or frequent headaches ?	Y/N
Rheumatoid or arthritic conditions ?	Y/N	Polio, mononucleosis, TB or pneumonia?	Y/N
Skin disorders ?	Y/N	Shingles ?	Y/N
Cancer, tumor, radiation treatment, or chemotherapy ?	Y/N	Problems with immune system ?	Y/N
HIV positive or AIDS ?	Y/N	Blood transfusion ?	Y/N
Venereal disease ?	Y/N	Heart attack or stroke ?	Y/N
Chest Pain, shortness of breath or swelling of ankles ?	Y/N	High or Low blood pressure ?	Y/N
Heart surgery / pacemaker / artificial value ?	Y/N	Heart Murmer / mitral valve prolapse ?	Y/N
Are you pregnant ?	Y/N	Rheumatic Fever ?	Y/N

Operations / Hospitalizations ?
Other problems or symptoms ?

Acknowledgment: I have read and understand the above registration form. I will not hold Dr. Bertha Dieguez-Marino or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice. In addition, I have received a copy of this office's notice of privacy practices.

Consent to undergo Orthodontic Treatment: I hereby consent to the making of diagnostic records, including x-rays, before, during and after orthodontic treatment prescribed by the doctor as well as to the staff and doctor providing the prescribed orthodontic treatment for the above patient. I fully understand all of the risks associated with treatment.

Assignment of benefits: I hereby give permission to bill my insurance company for the services rendered by Dieguez-Marino Orthodontics P.C., and I agree to assist in the processing all claims for benefits. I hereby authorize direct payment of benefits to Dieguez-Marino Orthodontics P.C.

Financial Responsibility: I hereby agree to be responsible for all charges for services rendered to the patient including any non-covered charges. I also agree that if the unpaid account is referred to a collections agency, to pay all costs of collections, including reasonable fees of one-third of the balance due.

Signed by Patient (Agreement to Pay) **Date:**

SUBMIT