



Dr. Gordon Barfield DDS & Dr. Maria Lewis DMD

**ADULT PATIENT REGISTRATION**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

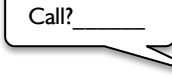
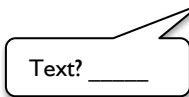
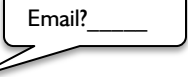
Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Social Security # \_\_\_\_\_ Home phone \_\_\_\_\_

Work phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_

How do you prefer to be contacted to remind you of future appointments?  
Put a check in the box:   

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Any friends or family members we have treated? \_\_\_\_\_ Name(s)? \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Policyholder Name \_\_\_\_\_ Policyholder SSN # \_\_\_\_\_ Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_ No \_\_\_ If yes:

Policyholder Name \_\_\_\_\_ Policyholder SSN # \_\_\_\_\_ Birth Date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Phone No. \_\_\_\_\_

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Are you allergic to anything? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have you ever smoked or chewed tobacco? \_\_\_\_\_  
Yes No Have you seen a physician in the last 12 months? Why? \_\_\_\_\_  
Yes No Female Patients only: Are you pregnant? \_\_\_\_\_  
Yes No Does the patient typically take antibiotics before dental cleanings? Why? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

## DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have your wisdom teeth been removed? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_  
Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_  
Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_  
Yes No Are you aware that some appointments will be during work hours? \_\_\_\_\_

## BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I understand that, where appropriate, credit bureau reports may be obtained. In addition, I consent to a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_