

**H.L. STRICKLAND, JR., D.D.S., P.A.**

Specialist in Orthodontics

For

Adult and Children

OFFICE LOCATIONS:

EASTERN SHORE

BAY MINETTE

FOLEY

**REGISTRATION HISTORY ADULT**

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

DO YOU HAVE ANY FRIENDS/RELATIVES THAT ARE OR HAVE BEEN PATIENTS HERE? \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

LOCATION ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ POSITION \_\_\_\_\_

IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_ MARRIED \_\_\_ DIVORCED \_\_\_ SEPARATED \_\_\_ WIDOWED \_\_\_

NAME OF SPOUSE \_\_\_\_\_

WHO WILL PAY THIS ACCOUNT \_\_\_\_\_

NAME OF PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

MAY WE REQUEST YOUR HEALTH RECORDS IF NECESSARY? YES \_\_\_\_\_ NO \_\_\_\_\_

DATE OF LAST HEALTH EXAMINATION \_\_\_\_\_ FOR WHAT \_\_\_\_\_

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS \_\_\_\_\_ FOR WHAT \_\_\_\_\_

IF ALLERGIES TO MEDICATIONS OR DRUGS, INDICATE WHICH ONES \_\_\_\_\_

ARE YOU ON ANY MEDICATION \_\_\_\_\_ FOR WHAT? \_\_\_\_\_

OTHER PHYSICAL, MEDICAL OR EMOTIONAL CONDITIONS \_\_\_\_\_

GENERAL DENTIST \_\_\_\_\_ PURPOSE OF THIS APPOINTMENT \_\_\_\_\_

IF TREATMENT IS NECESSARY, HOW SOON WOULD YOU PREFER TO BEGIN? \_\_\_\_\_

HAVE YOU EVER HAD?

	YES	NO		YES	NO
ANEMIA	___/___		TONSILS/ADENOIDS OUT	___/___	
DIABETES	___/___		EPILEPSY	___/___	
GROWTH DISORDER	___/___		RHEUMATIC FEVER	___/___	
BONE PROBLEMS	___/___		ABNORMAL BLOOD PRESSURE	___/___	
HEART PROBLEMS	___/___		HEPATITIS	___/___	
HEART MURMER	___/___		WOMEN – ARE YOU PREGNANT	___/___	
ASTHMA	___/___				
ALLERGIES TO MEDS	___/___				

Have there been any injuries to the face, mouth, teeth or scars? When? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Has the patient ever sucked a thumb or finger (until what age? \_\_\_\_\_) \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Does the patient grind or clench his/her teeth? At night? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Does the patient have clicking, popping or pain upon closing the mouth? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Have you been informed of any missing permanent teeth? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Have you been informed of any extra permanent teeth? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Has an orthodontist been consulted previously? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Does anyone in the family have similar dental/orthodontic conditions? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Did they have any orthodontic treatment? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Is patient adopted or foster? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Does the patient desire orthodontic treatment? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Who first noticed the need for orthodontic treatment? General Dentist \_\_\_\_\_

Parent \_\_\_\_\_ Patient \_\_\_\_\_ When? \_\_\_\_\_

Have any appliances been placed in the patient's mouth to maintain space? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Are you aware that some appointments will infringe on school time? Or work? \_\_\_\_\_ YES NO  
\_\_\_/\_\_\_

Other relevant information you feel Dr. Strickland should be aware of. \_\_\_\_\_