Matthew Sanders, DDS, MS
(916) 635-5717

2865 Sunrise Blvd, Suite 114
Rancho Cordova, CA

PATIENT REGISTRATION & INFORMATION

Date: ____________

Last Name_________________________ First__________________________ Middle_________________ Sex_____

Birthdate___________ Age____ Phone No.__________________ Patient's Email_________________________
Home / Mobile / Work

Preferred method for automated appointment reminders (please circle ONE): EMAIL / TEXT MESSAGE / PHONE CALL

Address – Street____

City____ State___________ Zip Code______________

Name of Dentist / Dental Office____

Address____ Phone No.________________

Whom may we thank for referring you to our practice?_____________________________________

Adult Patient: Single________Married________Widowed________Separated________Divorced________

Occupation____Business Phone No.________________

Minor Patient: Birth Weight__________ Present Weight__________ Height____________

School____ Grade Level________________

Favorite Sports and Hobbies____

Musical Instruments Played____

Number of Brothers and Sisters_________________________________ Ages___________________

Other Family Members Treated____

Responsible Party Information, *please list anyone who will be bringing the minor patient to appointments, responsible for financial matters, and responsible for treatment matters*

Full Name__________________________________Sex______ Relationship to Patient______________

Birthdate____________ Phone Number _________________ Email_______________________________

Full Name__________________________________Sex______ Relationship to Patient______________

Birthdate____________ Phone Number _________________ Email_______________________________

Full Name__________________________________Sex______ Relationship to Patient______________

Birthdate____________ Phone Number _________________ Email_______________________________

DENTAL (ORTHODONTIC) Insurance Coverage Yes________ No__________

Insurance Co. Name_____________________________________ Policy/Group No.__________________

Subscriber's Name_______________________________ **DOB:** ___________ Relationship to Patient______________

Subscriber's SSN # ___________________________ Subscriber's Insurance ID# _______________________

*** The Social Security Number is* ***required*** *if a member/subscriber ID number is not known.*

Subscriber's Address (if different than patient's address)_________________________________

City____ State___________ Zip Code______________

The following information is ***required*** *if the insurance plan is provided by an employer*

Company Name____ Group No. ____________________

Company Phone No.__________________ Address ____

City____ State___________ Zip Code______________

In Case We Cannot Reach You:

Name:__________________________ Phone No.___________________ Relationship to Patient______________

Please continue on the back side…

For the following questions circle **yes**, **no**, or **don't know/understand (dk/u)**. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Medical History

Minors Only

yes no dk/u Started teething very early or very late?
yes no dk/u Does patient have trouble following directions?
yes no dk/u Does patient have learning disabilities or need extra help with instructions?
yes no dk/u Are you taking birth control pills?
yes no dk/u Is patient sensitive, self-conscious?

Adults and Minors

yes no dk/u Birth defects of hereditary problems?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Kidney problems?
yes no dk/u Cancer or been treated for a tumor?
yes no dk/u Problems of the immune system?
yes no dk/u Vision, hearing, tasting, or speech difficulties?
yes no dk/u Fainting spells, seizures, epilepsy, or neurologic problem?
yes no dk/u Do you have a poor and unhealthy diet?
yes no dk/u Sexually transmitted diseases? Please list:________________
yes no dk/u Chest pain, shortness of breath, or swelling ankles?
yes no dk/u Hayfever, asthma, sinus trouble, hives?
yes no dk/u Currently have or ever had a substance abuse problem?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u High or low blood pressure?
yes no dk/u Polio, mono, tuberculosis, pneumonia?
yes no dk/u Tires easily?
yes no dk/u AIDS or HIV positive?
yes no dk/u Eye, ear, nose, throat, tonsil, adenoid conditions?
yes no dk/u Hepatitis, jaundice or liver problem?
yes no dk/u Are you pregnant or expecting to become pregnant?
yes no dk/u Are there any mental health problems? Please list: ____
yes no dk/u Excessive bleeding, black and blue tendency, anemia, or bleeding disorder?
yes no dk/u Cardiovascular problem, heart trouble, heart attack, angina, coronary insufficiency, arterlosclerosis, stroke, inborn heart defects, or rheumatic heart?
yes no dk/u Allergies or drug reactions? Please list: ____
yes no dk/u Are you taking medication, supplements, or non-prescription medicine? Please list:____________________
yes no dk/u Operations/Surgical procedures/Hospitalizations for: ________________________________
yes no dk/u Other physical problems or symptoms?____
yes no dk/u Is the patient seeing any other health care professional? For________________________________

Dental History

Minors Only

yes no dk/u Does patient have trouble following directions?
yes no dk/u Removal of (baby) teeth that were not loose?
Onset of puberty (approximate age)_________

Adults and Minors

yes no dk/u Prior orthodontic treatment? When?___________
yes no dk/u Permanent or "extra" (supernumerary) teeth removed?
yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
yes no dk/u "Dead Teeth", root canals treated?
yes no dk/u Thumb, finger, sucking habit? Until________________
yes no dk/u Abnormal swallowing habit (tongue thrusting)?
yes no dk/u Mouth breathing habit, snoring, difficulty in breathing?
yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
yes no dk/u Aware or concerned about under or over developed jaw?
yes no dk/u Concerned about spaced, crooked, protruding teeth?
yes no dk/u Has patient ever had periodontal (gum) treatment?
yes no dk/u Jaw fractures, cysts, mouth infections?
yes no dk/u Bleeding gums, bad taste, mouth odor?
yes no dk/u Periodontal disease, "Gum Problems"?
yes no dk/u Food impaction between teeth?
yes no dk/u History of speech problems?
yes no dk/u Difficulty chewing or opening jaw?
yes no dk/u Any pain in jaw or ringing in the ears?
yes no dk/u Any relative with similar tooth or jaw problems?
yes no dk/u Loose, broken, or missing restorations (fillings)?
yes no dk/u Any wisdom tooth problems?
yes no dk/u Have you ever been treated for "TMJ" problems (Your jaw joint and facial muscle pain?)
yes no dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
yes no dk/u Has patient had any serious trouble associated with any previous dental treatment?
yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date of last dental visit_________ Were x-rays taken? Yes / No / DK/U Date of last cleaning________ How often does patient brush?_________ Floss?__________

What is the patient's (or guardian's) primary concern? Why are you here today?____
____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/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.

Signature of patient/guardian **Printed Name** **Date**

Dr. Matthew A. Sanders **Date**

MEDICAL & DENTAL HISTORY UPDATE – Should be completed at least once a year. Are there any changes to your medical and dental history that we should be aware of? Please write "none" or explain:________________________________

Signature of patient/guardian **Printed Name** **Date**

Dr. Matthew A. Sanders **Date**