LEONE & VAUGHN
orthodontics
www.landvortho.com

This is a fillable form. Please type your information.

PATIENT REGISTRATION

Account #________________

Patient Name ____ Birth Date ____/____/______

Patient's Mailing Address __________________________________ Home Phone__________________

City __________________________ State ____ Zip___________ Work Phone__________________

Patient's E-Mail ____ Cell Phone ___________________

SSN:_____-_____-_______ Sex: M / F Marital Status:________________________________

Patient's Dentist ________________________Whom may we thank for this referral? ____________

Patient's main concern ____

Responsible Party (if Patient is a minor)

Name ____ Relationship to Patient _____________
SSN _____-_____-_________ Other Parent: ____
Mailing Address ____________________________________ Home Phone _______________________
City ________________________ State ____ Zip_________ Work Phone _______________________
How long at this address? __________________________ Cell phone _______________________
Marital Status: Single Married Separated Divorced Domestic Partner Widowed
Employer _______________________ Occupation ______________________ How long? __________

Orthodontic Insurance Information

Insurance #1____________________________
Subscriber's Name________________________
DOB ___/___/____ SSN____-____-_____
Group # __________ I.D. # ______________
Insurance Phone Number _________________
PT's relationship to Subscriber: ____________
Subscriber's Employer ____________________
____

Insurance #2____________________________
Subscriber's Name________________________
DOB ___/___/____ SSN____-____-_____
Group # __________ I.D. # ______________
Insurance Phone Number_________________
PT's relationship to Subscriber: ____________
Subscriber's Employer ____________________
____

Emergency Contact (Person not living with Patient)

Name____
Address ____ Home Phone ____________________
Relationship to Patient ____________________________________ Work phone ____________________

The information that I have given is correct to the best of my knowledge.

Signature____ Date _____/______/_____

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HEALTH QUESTIONNAIRE

Patient Name ____Today's Date ______/______/______
Physician Name ________________________________ Physician Phone #: (_____) ______________

Please circle your response: Do you now or have you ever had any of the following diseases or conditions?

Condition			Condition		
Aids (HIV)	Yes	No	Kidney disease or infection	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bladder Disease or infection	Yes	No	Measles	Yes	No
Blood Disorders	Yes	No	Mumps	Yes	No
Chicken Pox	Yes	No	Painful or swollen joints	Yes	No
Diabetes (Sugar disease)	Yes	No	Polio	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No
Glaucoma	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Severe Headaches	Yes	No
Hemophilia	Yes	No	Sexually Transmitted Disease	Yes	No
Hepatitis A ,B ,C	Yes	No	Stroke	Yes	No
Herpes	Yes	No	Tuberculosis	Yes	No
Jaundice (Yellow skin or eyes)	Yes	No	Ulcers	Yes	No

Have you ever been told by a physician that you have a heart murmur? .... Yes No
Has your physician recommended pre-medication with antibiotics before dental treatment? Yes No

Do you now have or have you ever had any heart trouble? (i.e. Rheumatic fever, angina, etc.)........... Yes No
Do you have any **allergies (to latex, metal, etc)? Yes No Please List** ________________________

Have you ever experienced any unusual **reactions or allergies** to any of the following drugs?

Drug			Drug		
Penicillin	Yes	No	Novocain	Yes	No
Antibiotics	Yes	No	Sulfa drugs	Yes	No
Aspirin	Yes	No	Others: Please List		

Do you have high blood pressure? .... Yes No
Do you have any artificial prostheses in your body? (i.e. metal screws, plates, joints etc.) Yes No
*** If YES**, please specify ____
Do you now or have you ever used tobacco products? .... Yes No
Have you been examined by a physician within the last year? .... Yes No
Have you ever been hospitalized?... Yes No
***If YES,** please explain____
Have you ever had a blood transfusion? .... Yes No
Have you ever been treated for a growth or tumor in any part of your body? .... Yes No
Women – Are you presently pregnant?... Yes No
Girls– Have you begun menstrual periods?.. Yes No

Please list all current medications and herbal or supplements you are currently taking:

Name of Medication/Supplement Dosage/mg Frequency Condition

______________________________ ____________ __________ ____________________________________

______________________________ ____________ __________ ____________________________________

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient signature (Parent if a minor) ____ Date_____________