



OLYMPIC ORTHODONTICS

Frederick L. Johnston D.D.S.

7048 Dublin Blvd. • Dublin, CA 94568 • (925) 833-0535 • Fax (925) 833-8019 • www.olympicorthodontics.com

PATIENT REGISTRATION HISTORY - ADULT

Mr. Mrs. DATE ____/____/____

Ms. Dr. _____ MALE FEMALE D.O.B. _____
First Middle Last

HOME ADDRESS _____
Street City State Zip

HOME PHONE _____ CELL _____ E-MAIL _____

BUSINESS PHONE _____ EMPLOYER _____

SPOUSE'S NAME _____ D.O.B. _____

PATIENT'S SOCIAL SECURITY # _____ SPOUSE'S SOCIAL SECURITY # _____

REFERRED BY? _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ DATE OF LAST VISIT ____/____/____

MEDICATIONS CURRENTLY TAKING:

PLEASE CHECK YES OR NO TO THE FOLLOWING:

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient had a physical exam in the last year? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient presently under a physician's care? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever been hospitalized? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is patient taking any pills, medication or drugs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had major surgery? |

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient had any reactions to any medications? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient had his/her tonsils and/or adenoids removed? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient experience fainting or dizzy spells? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient have too high or too low blood pressure? |

HAS PATIENT BEEN DIAGNOSED OR TREATED FOR:

- | | | | | | |
|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung problems | <input type="checkbox"/> | <input type="checkbox"/> | Malignancies |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver problems | <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine problems | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Bone |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | AIDS |

PLEASE CHECK IF PATIENT IS ALLERGIC TO THE FOLLOWING:

- Aspirin Codeine Penicillin Sulfa Latex Metals
 Other _____

Dr Notes:

MEDICAL ALERT
YES NO

Are there any other medical problems I should be aware of? _____

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____ DATE OF LAST CLEANING ____/____/____

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had orthodontic consultations or treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient been informed of any missing teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have any permanent teeth been removed by extraction? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has a family member had orthodontic treatment?
Who? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient breathe predominately through his/her mouth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient have any speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient now suck his/her thumb or finger? |

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient grind or clench his/her teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient have pain or clicking of the jaw joint? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had any teeth injured due to an accident? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had pains in the face? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has patient ever had a severe jaw or head injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient want his/her teeth straightened? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does patient's gums bleed when brushing or flossing? |

Are there any other dental/orthodontic problems I should be aware of? _____

PATIENT SIGNATURE _____ DATE ____/____/____

DR SIGNATURE _____ DATE ____/____/____