University of Florida College of Dentistry
Department of Orthodontics
Patient Registration Form

Patient Information

Patient Last Name	First Name	Middle Name
Guardian Name (if patient is 18 years or younger)		
Mailing Address (include apartment number)		
City	State	ZIP code
Employment Status (select one) Employed Full-time Student Part-time Student		Birthdate (mm/dd/yyyy)
Home phone (with area code) ( )	Work phone (with area code) ( )	Marital status (select one)
Driver's License Number & State		

Emergency Contact

Name	Phone (with area code) ( )	Relationship to patient

Optional Demographic and Financial Information

This optional demographic and financial information is being asked to better understand the patients served by the College of Dentistry. This information is used to request additional funds from the government and other sources, to help keep the cost of dental care affordable for our patients.

Ethnic Origin (Select one) Asian African American Caucasian/White Hispanic American Indian/Alaskan Native Native Hawaiian Pacific Islander Other (Specify) _____
Number in Household (Select one) I 2 3 4 5 6 7 8 9 10 or more
Gross Annual Household Income $ _____ Per Year

Patient Name: _____ **Date**: _____

Please answer all questions by circling the best response. Your doctor will discuss your answers with you.

Reason for your visit: _____

How long have you had this condition? _____

General Questions

Is your general health good at present? Yes No

Are you under the care of a physician? Yes No

If so, why? _____

Have you been admitted to a hospital? Yes No

If so, why? _____

Surgical History

Have you had previous operations? Yes No

Please describe _____

Heart Conditions

Heart Attack/MI	Yes	No
Angina/Chest Pain	Yes	No
High Blood Pressure	Yes	No
Prosthetic Heart Valve	Yes	No
Congestive Heart Failure	Yes	No
Heart Bypass/Stent Surgery	Yes	No
Congenital Heart Defect	Yes	No
Pacemaker/Defibrillator	Yes	No
Infective Endocarditis	Yes	No
Heart Palpitations	Yes	No
Irregular Heart Beat	Yes	No
Rheumatic Heart Disease	Yes	No

Breathing Problems

Asthma	Yes	No
Tuberculosis	Yes	No
Sleep Apnea	Yes	No
Bronchitis/Emphysema/ COPD	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Pneumonia	Yes	No

Endocrine Problems

Diabetes	Yes	No
Thyroid Disorders	Yes	No

Blood Conditions

Anemia	Yes	No
Sickle Cell Disease	Yes	No
HIV disease/AIDS	Yes	No
Bleeding disorders (e.g. Hemophilia/on Coumadin)	Yes	No
Warfarin Treatment	Yes	No
Bruising Easily	Yes	No

Head, Eyes, Ears, Nose & Throat

Frequent Headaches	Yes	No
Jaw Joint/TMJ Popping, Catching, Pain	Yes	No
Glaucoma	Yes	No
Sinus or Nasal Problems	Yes	No

Digestive Problems

Hepatitis/Jaundice	Yes	No
Liver Disease	Yes	No
GERD/Reflux/Ulcers	Yes	No

Nervous System Problems

Stroke/TIA/Mini-Stroke	Yes	No
Epilepsy/Seizure Disorder	Yes	No
Neuropathy/Nerve Pain	Yes	No

Psychiatric Problems

Depression	Yes	No
Panic/Anxiety Disorder	Yes	No
Other Psychiatric or Emotional Disorders	Yes	No

Other Problems

Renal/Kidney	Yes	No
Prostate Disease	Yes	No
Organ Transplant	Yes	No
Cancer/Tumors	Yes	No
Radiation/Chemotherapy	Yes	No
Arthritis	Yes	No
Artificial Joint/Joint Replacement	Yes	No
Any other problems?	Yes	No

Describe: _____

_____

_____

For Women Only

Are you nursing?	Yes	No
Are you/could you be pregnant?	Yes	No

Family History

Cancer	Yes	No
Arthritis	Yes	No
Heart Disease	Yes	No
Hypertension	Yes	No
Anesthesia Complications	Yes	No

Social History

Smoking/Tobacco Use	Yes	No
Alcoholic Beverages	Yes	No
Recreational (Street) Drugs	Yes	No

Allergies

Pain Medicine(s)	Yes	No
Penicillin/Amoxicillin	Yes	No
Other Antibiotics	Yes	No
Local Anesthetics	Yes	No
Other Medicines	Yes	No
Latex/Glove Powder	Yes	No
Environmental/Seasonal	Yes	No
Other Allergies	Yes	No

List Allergic Reactions: _____

_____

_____

Medications

Anticoagulants (blood thinners)	Yes	No
Aspirin	Yes	No
Coumadin	Yes	No
Plavix	Yes	No
Bisphosphonates(Reclast, Fosomax, Actonel, Boniva, Aredia, Zometa)	Yes	No
Other Medicines	Yes	No
Steroids	Yes	No
Birth Control Pills	Yes	No

Other Drugs (List Drug Name & Dose):

_____

_____

_____

Supplements (Diet Supplements, Natural or Herbal Vitamins):

_____

_____

_____

Signature: _____ Date: _____