FERRIS
ORTHODONTIC GROUP

Santa Barbara Office
805-687-7417

Goleta Office
805-964-4786

Adult New Patient Registration

Patient Information

Patient's Name:

Gender:

☐ Male ☐ Female

Social Security Number

Date of Birth

Driver's License Number

Home Address

City

State

Zipcode

Primary Phone Number

Phone Type

☐ Home ☐ Cell ☐ Other

Secondary Phone Number

Phone Type

☐ Home ☐ Cell ☐ Other

Email Address

Employer's Name

Occupation

Spouse/Emergency Contact Information

Marital Status

-- Choose One --

Spouse/Partner's Name

Relation to You

Phone Number

Street Address

City

State

Zipcode

Person(s) OK to release appointment or medically related information to concerning you

Relation to You

Primary Insurance Information

Primary Insurance Company

Phone Number

Group Number

Policy Number

Member ID Number

Policy Holder's Name

Policy Holder's Birth Date

Employer

Work Phone Number

Co-Pay (if known)

Deductible (if known)

Secondary Insurance Information

Secondary Insurance Company

Phone Number

Group Number

Policy Number

Member ID Number

Policy Holder's Name

Policy Holder's Birth Date

Employer

Work Phone Number

Co-Pay (if known)

Deductible (if known)

Dental History

General Dentist

Date of Last Visit

How did you hear about our practice?

- [ ] Ad
- [ ] Internet
- [ ] Family or Friend
- [ ] Physician
- [ ] Other

Name of person referring (if applicable)

What are your main orthodontic concerns?

Have you visited an orthodontist before?

- [ ] Yes
- [ ] No

When?

For what reason?

Have your tonsils or adenoids been removed?

☐ Yes ☐ No

Do you have any missing or extra permanent teeth?

☐ Yes ☐ No

Do you have speech problems?

☐ Yes ☐ No

Do your gums bleed?

☐ Yes ☐ No

Do you like your smile?

☐ Yes ☐ No

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)?

☐ Yes ☐ No

Have you ever had an injury to the following? (select all that apply)

☐ Teeth ☐ Mouth ☐ Chin

If 'yes' please explain

Do you smoke?

☐ Yes ☐ No

Do you currently or have you ever had any of the following habits?

☐ Clenching/Grinding Teeth ☐ Lip Sucking/Biting

☐ Mouth Breathing ☐ Nail biting

☐ Thumb/ Finger Sucking ☐ Chewing/Eating Problems

Medical History

Are you currently being treated by a physician?

☐ Yes ☐ No

Reason

Physician's Name

Date of Last Visit

Physician's Phone Number

Do you have any allergies/sensitivities to medications or latex?

☐ Yes ☐ No

If 'yes' please list allergies

Are you currently taking any prescription or over-the-counter medications?

☐ Yes ☐ No

If 'yes' please list (with dosages)

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"?

☐ Yes ☐ No

Have you had any serious illnesses or operations?

☐ Yes ☐ No

If 'yes' please describe

Have you ever had a blood transfusion?

☐ Yes ☐ No

If 'yes' please list approximate dates

Are you pregnant? (Women)

☐ Yes ☐ No

Nursing?

☐ Yes ☐ No

Taking birth control pills?

☐ Yes ☐ No

Check if you have or have ever had any of the following:

- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Arthritis or Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Defect
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Coughing Blood
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug/Alcohol/Abuse
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fainting
- ☐ Fever Blisters/Herpes
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High/Low Blood Sugar
- ☐ HIV/AIDS
- ☐ Hospitalized for Any Reason
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease/Traits
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

Authorization

☐ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status. I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance. I understand that where appropriate, credit bureau reports may be obtained.

Signature of Patient or Responsible Party

Today's date