

NO. _____

Michael F. Grosso, O.M.D.
Practice Limited to Orthodontics

ORTHODONTIC REGISTRATION

DATE _____

PATIENTS FULL NAME _____ NICKNAME _____

BIRTH DATE _____ AGE _____ SEX MALE FEMALE

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW DID YOU HEAR OF US? _____ HOME PHONE _____ LISTED UNLISTED

DENTIST: _____ PHYSICIAN _____

EMPLOYED BY _____

BUSINESS ADDRESS _____ POSITION _____
BUSINESS PHONE _____ BUSINESS PHONE _____

MARRIED: NO YES IF YES, SPOUSE'S NAME _____

SPOUSE'S BUSINESS ADDRESS _____ POSITION _____
BUSINESS PHONE _____ BUSINESS PHONE _____

DO YOU HAVE ORTHODONTIC DENTAL INSURANCE? YES NO IF YES, NAME OF INSURANCE CARRIER _____
GROUP NO. _____ UNION NO. _____

PERSON RESPONSIBLE FOR THIS ACCOUNT SELF SPOUSE OTHER

NAME OF RESPONSIBLE PERSON IF NOT PATIENT OR SPOUSE _____
BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

HAVE YOU EVER HAD ANY PREVIOUS ORTHODONTIC CONSULTATION OR TREATMENT? YES NO REMARKS: _____

HAS ANY OTHER FAMILY MEMBER RECEIVED ORTHODONTIC CARE? YES NO IF YES, WHO? _____

SIGNATURE OF PATIENT _____ DATE _____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- | | | | |
|-----|--|-----|----|
| 1. | Has there been any change in your general health within the past year | YES | NO |
| 2. | My last physical examination was on _____ | | |
| 3. | Are you now under the care of a physician | YES | NO |
| | a. If so, what is the condition being treated _____ | | |
| 4. | Have you had any serious illness or operation | YES | NO |
| | a. If so, what was the illness or operation _____ | | |
| 5. | Have you been hospitalized or had a serious illness within the past five (5) years | YES | NO |
| | a. If so, what was the problem _____ | | |
| 6. | Do you have or have you had any of the following diseases or problems. | | |
| | a. Rheumatic fever or rheumatic heart disease | YES | NO |
| | b. Congenital heart lesions | YES | NO |
| | c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | YES | NO |
| | 1) Do you have pain in chest upon exertion | YES | NO |
| | 2) Are you ever short of breath after mild exercise | YES | NO |
| | 3) Do your ankles swell | YES | NO |
| | 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep | YES | NO |
| | d. Allergy | YES | NO |
| | e. Sinus trouble | YES | NO |
| | f. Asthma or hay fever | YES | NO |
| | g. Hives or a skin rash | YES | NO |
| | h. Fainting spells or seizures | YES | NO |
| | i. Diabetes | YES | NO |
| | 1) Do you have to urinate (pass water) more than six times a day | YES | NO |
| | 2) Are you thirsty much of the time | YES | NO |
| | 3) Does your mouth frequently become dry | YES | NO |
| | j. Hepatitis, jaundice or liver disease | YES | NO |
| | k. Arthritis | YES | NO |
| | 1) Inflammatory rheumatism (painful swollen joints) | YES | NO |
| | m. Stomach ulcers | YES | NO |
| | n. Kidney trouble | YES | NO |
| | o. Tuberculosis | YES | NO |
| | p. Do you have a persistent cough or cough up blood | YES | NO |
| | q. Low blood pressure | YES | NO |
| | r. Venereal disease | YES | NO |
| 7. | Have you had abnormal bleeding associated with previous extractions, surgery, or trauma | YES | NO |
| | a. Do you bruise easily | YES | NO |
| | b. Have you ever required a blood transfusion | YES | NO |
| 8. | Do you have any blood disorder such as anemia | YES | NO |
| 9. | Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips | YES | NO |
| 10. | Are you taking any drug or medicine | YES | NO |
| 11. | Are you taking any of the following: | | |
| | a. Antibiotics or sulfa drugs | YES | NO |
| | b. Anticoagulants (blood thinners) | YES | NO |
| | c. Medicine for high blood pressure | YES | NO |
| | d. Cortisone (steroids) | YES | NO |
| | e. Tranquilizers | YES | NO |
| | f. Antihistamines | YES | NO |
| | g. Aspirin | YES | NO |
| | h. Insulin, tolbutamide (Orinase) or similar drug | YES | NO |
| | i. Digitalis or drugs for heart trouble | YES | NO |
| | j. Nitroglycerin | YES | NO |
| | k. Other _____ | | |
| 12. | Are you allergic or have you reacted adversely to: | | |
| | a. Local anesthetics | YES | NO |
| | b. Penicillin or other antibiotics | YES | NO |
| | c. Sulfa drugs | YES | NO |
| | d. Barbiturates, sedatives, or sleeping pills | YES | NO |
| | e. Aspirin | YES | NO |
| | f. Iodine | YES | NO |
| | g. Codeine or other narcotics | YES | NO |
| | h. Other _____ | | |
| 13. | Have you had any serious trouble associated with any previous dental treatment | YES | NO |
| | If so, explain _____ | | |
| 14. | Do you have any disease, condition, or problem not listed above that you think I should know about ... | YES | NO |
| | If so, explain _____ | | |
| 15. | Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ... | YES | NO |
| 16. | Are you wearing contact lenses | YES | NO |
| 17. | Are you pregnant | YES | NO |
| 18. | Do you have any problems associated with your menstrual period | YES | NO |

SIGNATURE OF PATIENT