REICHL & KOLSTAD ORTHODONTICS

Specialists in Orthodontics and Dentofacial Orthopedics

ADULT REGISTRATION FORM

Patient's Last Name: _____ **First Name**: _____ **Nickname**: _____

Birth Date: _____ Age: _____ Gender: M F

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: Single Married Separated Divorced Widowed Domestic Partner

Your Employer: _____ Work Phone #: _____

How were you referred to our office? Dentist: _____ Friend: _____

Ad: _____ Mail Flyer: _____ School Tour: _____ Internet: _____

Financially Responsible Party or Spouse's Name: _____ Birth Date: _____

Employer: _____ Work Phone#: _____

Cell Phone: _____ Email: _____

Relationship to Patient: Self Spouse Child Other: _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder: _____

Insurance Company: _____

Group #: _____

ID#: _____

Address: _____

Phone # on Ins. Card: _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder: _____

Insurance Company: _____

Group #: _____

ID#: _____

Address: _____

Phone # on Ins. Card: _____

OVER

MEDICAL HISTORY

Name of Physician:	Describe if you are currently under medical care:
List any medications now being taken:	
List any allergies:	

PLEASE CHECK ANY OF THE FOLLOWING THE PATIENT HAS OR HAS HAD:

☐	Premedication for Dental Treatment	☐	Diabetes	☐	Ear Problems
☐	Prosthetic Cardiac Valve	☐	Osteoporosis/Bone Disorder	☐	Sinus Problems
☐	Previous Infective Endocarditis	☐	Epilepsy/Seizures/Fainting/Dizziness	☐	Tonsils/Adenoids Removed
☐	Unrepaired Cyanotic Congenital Heart Disease	☐	Kidney or Liver Problems	☐	Autism
☐	Repaired Congenital Heart Defect	☐	Hepatitis	☐	ADHD
☐	Cardiac Transplantation	☐	Tuberculosis (TB)	☐	Developmental Problems
☐	Tumors, Radiation, or Chemotherapy	☐	HIV+/AIDS	☐	Learning Disability
☐	Anemia or Abnormal Bleeding	☐	History of Tobacco Use	☐	Speech Therapy
☐	Asthma				
☐	Use of Bisphosphonate Medication(s) – Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, or Zometa				

Use space below for further explanations:

ORTHODONTIC AND DENTAL HISTORY

Name of General Dentist: _____

List any uncompleted dental treatment: _____

What concerns do you have that prompted this visit? _____

Describe any previous orthodontic treatment or consultations: _____

_____

Have other members of your family had orthodontic treatment? _____

PLEASE CHECK ANY OF THE FOLLOWING THE PATIENT HAS OR HAS HAD:

☐	Clicking/Popping or other TMJ noises	☐	Lip biting	☐	Grinding/clenching of teeth
☐	Pain in TMJ or facial muscles	☐	Mouth breathing	☐	Tongue thrusting
☐	Jaw that locks in an open or closed position	☐	Unfavorable reaction to dental care	☐	Snoring
☐	Prior treatment for TMJ problems	☐	Thumb/finger sucking (until age_____)	☐	Nail biting
☐	Injury to teeth (list teeth & date of injury):				

To the best of my knowledge, the information on the front and back of this form is complete and accurate. I hereby authorize insurance payment for orthodontic services rendered to be sent directly to Reichl & Kolstad Orthodontics. Any amount not covered by insurance will remain my full responsibility. I authorize taking diagnostic orthodontic records, and release of any dental or medical information necessary to process insurance claims. I understand, where appropriate, credit bureau reports may be obtained.

My signature on this form acknowledges that I understand the ways in which my health information may be used or disclosed by Reichl & Kolstad Orthodontics on their Notice of Privacy Practices Information Sheet.

_____ _____

Patient's Signature Date

Telephone: (262) 547-2827 *2140 West St. Paul Ave., Suite A, Waukesha, WI 53188* *Fax: (262) 547-1269*

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HARTLAND WAUKESHA MUKWONAGO