Date: ____/____/____

ADULT REGISTRATION FORM

LAI ORTHODONTICS
Yu-Ching Lai, DDS, MS

PATIENT INFORMATION

❍ Mr. ❍ Ms. ❍ Dr. ❍ Miss ❍ Mrs.

First | M.I. | Last

Home Address Street | City | State | Zip

Telephone Home | Mobile | Office

❍ Male ❍ Female

Email Address | Date of Birth/Age | Social Security Number

Employer | Business Address

Married? ❍ Yes ❍ No

Spouse's Name

Employer | Business Address

Business Phone | Email Address

In case of emergency, contact: | Telephone

Who may we thank for this referral?

Reason for consultation:

BILLING

Name of person assuming financial responsibility (if not yourself):

Billing Address Street | City | State | Zip

E-mail Address | Telephone

Do you have orthodontic insurance coverage? ❍ Yes ❍ No
If DUAL COVERAGE, make sure to complete both primary and secondary carrier sections.

INSURANCE

Primary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | Date of Birth

Secondary Insurance Company Name

Address

Telephone

Employer

Group Number and ID Number

Social Security Number | *Date of Birth*

YOUR HEALTHCARE PROVIDERS

MEDICAL HISTORY

Physician's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Yes	No	
❍	❍	Are you in good health?
❍	❍	Have you ever been under the care of a physician for an illness?
❍	❍	Do you have any history of major illness?
❍	❍	Have you ever been hospitalized?
❍	❍	Are you taking any drugs or medications? (List below under Additional comments)
❍	❍	Are you allergic to any medication? (List below)
❍	❍	Have you had any unusual reaction to a medication?
❍	❍	Have you taken any diet medications (i.e., Fen-Fen)?
❍	❍	Have you taken bisphosphonates (i.e., Fosamax, Actonel, Zometa)?
❍	❍	Do you take sedatives, tranquilizers, sleeping pills or medicine to relax?
❍	❍	Do you have trouble sleeping?
❍	❍	Do you snore when sleeping?
❍	❍	Have your tonsils and/or adenoids been removed? If yes, at what age?
❍	❍	If female: Are you pregnant?
❍	❍	Are you taking birth control pills?

Additional explanations or comments:

Check whether you have/had any of the following conditions:

- ❍ Heart Problems
- ❍ Hepatitis
- ❍ Kidney Problems
- ❍ Rheumatic Fever
- ❍ Lung Problems
- ❍ Nervous Problems
- ❍ Liver Problems
- ❍ Psychiatric Care
- ❍ Allergies
- ❍ Malignancies
- ❍ HIV+/AIDS
- ❍ Endocrine Problems
- ❍ Epilepsy
- ❍ Bone Disorders
- ❍ Arthritis
- ❍ Prolonged Bleeding
- ❍ Anemia
- ❍ Asthma
- ❍ Tuberculosis
- ❍ Implants
- ❍ Diabetes

Are you allergic or have reacted adversely to:

Yes	No	
❍	❍	Local anesthetics
❍	❍	Penicillin/other antibiotics
❍	❍	Sulfa drugs
❍	❍	Barbiturates, sedatives or sleeping pills
❍	❍	Aspirin
❍	❍	Codeine or other narcotics
❍	❍	Latex
❍		Other: _____

DENTAL HISTORY

Dentist's Name | Telephone | Date of Last Visit

Address | City | State | Zip

Date of last dental exam: _____

Yes	No	
❍	❍	Have you previously consulted an orthodontist?
❍	❍	Have you ever had orthodontic treatment or been treated for a bad bite?
❍	❍	Is there clicking, popping or grating noise from your jaw when chewing?
❍	❍	Do you clench or grind your teeth?
❍	❍	Has there been any treatment for problems of your jaw joint or for facial muscle spasms?
❍	❍	Have there been any injuries to your face, mouth or teeth?
❍	❍	Have you had any previous unpleasant dental or orthodontic experiences? (Specify below)
❍	❍	Is there numbness or tingling associated with your mouth or face?
❍	❍	Do your gums bleed on brushing or flossing? How many times/week do you floss? _____
❍	❍	Have you ever had periodontal (gum) disease?
❍	❍	Do you have any speech problems?
❍	❍	Have you been informed of any missing or extra teeth?
❍	❍	Are you a mouth breather?
❍	❍	Do you use a mouth guard or plastic splint?
❍	❍	Human Immunodeficiency Virus (HIV)

Additional explanations or comments:

Signature: _____ **Date:** _____

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(ADULT)

I have received a copy of the Notice of Privacy Practices of ***Lai Orthodontics*** I hereby authorize, as indicated by my signature below, ***Lai Orthodontics*** to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number _____

☐ You may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date: Added / Removed: _____

2. _____ Date: Added / Removed: _____

3. _____ Date: Added / Removed: _____

4._____ Date: Added / Removed: _____

* * *

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____