ORTHODONTIC ASSOCIATES OF IOWA

KACI C. VELA, DDS, MS

NEW PATIENT REGISTRATION FORM–ADULT

Date ______________________________

Patient Name ______________________ Preferred Name __________________

Sex (M/F) _________ Age ______________ Birthdate ______________________

Address __________________ City _______________ State _____ Zip ________

Home# ___________________ Cell# ______________ Work# _______________

Which phone number do you prefer we use to contact you? ☐Home ☐Cell ☐Work

May we contact you via *text messaging* (rates may apply)? ☐Yes ☐No

Email ___________________________ May we contact you via email? ☐Yes ☐No

Place of employment/College ____

Do you have orthodontic insurance? ☐Yes ☐No Company ____________________

Policy Holder Name _______________ DOB ______ Policy ID# ________________

Who is your dentist? _______________________ Did they refer you here? ☐Yes ☐No

If no, whom may we thank for referring you to us? __________________________

Date of Last Dental Exam _________ Do you have a recent panoramic x-ray? ☐Yes ☐No

Have you been treated for any ***medical/psychological issues***?

Please explain ____

Are you taking any medications? (please list) _____________________________

Have you ever taken bisphosphonates? ☐Yes ☐No (please list) _______________

Have you had any injuries or operations involving the head, neck, or teeth? ☐Yes ☐No

Please explain ____

Do you have any drug allergies? ☐Yes ☐No (please list) ____________________

Do you have sensitivity to: *Latex*? ☐Yes ☐No *Gluten*? ☐Yes ☐No *Milk Protein*? ☐Yes ☐No

Have you ever had pain/clicking/tenderness of the jaw joint (*TMD/TMJ*)? ____________

Please explain ____

Why are you seeking orthodontic treatment (braces)? __________________________

Do you have a history of the following? (check all that apply)

☐Previous ortho tx _________________ ☐Underbite in the family _______________

☐Clenching/grinding/wear ____________ ☐Thumb/finger habit __________________

☐Missing/extra permanent teeth _________ ☐Extracted third molars ______________

It is important that the above information is correct and complete. It will be held in the strictest of confidence and used only for in-office treatment and paperwork. Your permission will be required to share given information with any other party.

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