OTAY LAKES ORTHODONTICS

A. Valeria Poggio, DDS, MS

891 Kuhn Dr Ste 205
Chula Vista, CA 91914
Tel. (619) 482-2412
Fax (619) 482-2442

PATIENT REGISTRATION
HISTORY - ADULT

DATE ____ / ____ / ____

☐ MR. ☐ MRS.

☐ MS. ☐ DR. _____ ☐ MALE ☐ FEMALE
FIRST MIDDLE LAST

HOME ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE _____ E-MAIL _____ CELL/PAGER _____

EMPLOYER _____ OCCUPATION _____ YEARS EMPLOYED ____

ADDRESS _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ / _____ / _____

MARRIED ☐ YES ☐ NO

SPOUSE'S NAME _____ SPOUSE'S OCCUPATION _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ PHONE _____ LAST VISIT ____ / ____ / ____

ADDRESS _____ MEDICAL ID# _____
(STREET) (CITY) (STATE) (ZIP)

YES NO
☐ ☐ Have you undergone a physical exam in the past year?
☐ ☐ Are you presently under a physician's care?
☐ ☐ Have you ever had a major surgery?
☐ ☐ Have you ever been hospitalized?
☐ ☐ Have you taken any pills, medication or drugs?
☐ ☐ Are you allergic to Novocain or penicillin?
☐ ☐ Have you had any unusual reaction to any medication?
☐ ☐ Have you had tonsils and/or adenoids removed?
☐ ☐ Do you have fainting or dizzy spells?
☐ ☐ Do you have a too high or low blood pressure?

Are there any other medical problems I should be aware of?
IF YES, PLEASE EXPLAIN _____

Have you ever been diagnosed or treated for the following?

YES	NO		YES	NO	
☐	☐	Heart Problems	☐	☐	Hepatitis
☐	☐	Kidney Problems	☐	☐	Rheumatic Fever
☐	☐	Lung Problems	☐	☐	Emotional Problems
☐	☐	Liver Problems	☐	☐	Malignancies
☐	☐	Allergies	☐	☐	Endocrine Problems
☐	☐	Diabetes	☐	☐	Bone Problems
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding
☐	☐	Anemia	☐	☐	Tuberculosis
☐	☐	Arthritis	☐	☐	Asthma

DENTAL HISTORY

DENTIST'S NAME _____ PHONE _____

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

WHAT IS THE MAJOR CONCERN ABOUT YOUR TEETH? _____

_____

DATE OF LAST CLEANING ____ / ____ / ____ ANY PENDING WORK? _____

YES NO
☐ ☐ Have you ever had previous orthodontic consultation or treatment?
☐ ☐ Have you ever been informed of any extra or missing teeth?
☐ ☐ Have any permanent teeth been removed by extraction?
☐ ☐ Has any family member had orthodontic treatment?
Who? _____
☐ ☐ Do you currently suck your thumb or finger?
☐ ☐ Have any teeth been injured or chipped due to an accident?
☐ ☐ Are you concerned about the appearance of your teeth?
Are there any other dental/orthodontic problems I should be aware of?

YES NO
☐ ☐ Do you grind or clench your teeth?
☐ ☐ Do you have pain or clicking of the jaw joint?
☐ ☐ Do you breathe predominantly through the mouth?
☐ ☐ Do you ever have pains in the face or head?
☐ ☐ Have you ever had severe jaw or head injury?
☐ ☐ Do your gums bleed on brushing or flossing?
☐ ☐ Do you have any speech problems?
☐ ☐ Do you want your teeth straightened?

Patient Signature _____ Date _____