Travis W. Wille, DDS, MS

PATIENT REGISTRATION

Date ______________________

Patient ______________________ (first, middle, last) Sex ________ Birthdate ______________ Age ______

Address ______________________ City ______________ State ________ Zip ______

Cell Phone ______________________ Work Phone ______________________

Employer ______________________ Email ______________________

General Dentist ______________________

Orthodontic Insurance ☐ No ☐ Yes

Spouse/Guardian 1 ______________________

Relationship to patient ______________________ Birthdate ______________

Address ______________________ City ______________ State ________ Zip ______

Cell Phone ______________________ Work Phone ______________________

Employer ______________________ Email ______________________

Orthodontic Insurance ☐ No ☐ Yes

Guardian 2 ______________________

Relationship to patient ______________________ Birthdate ______________

Address ______________________ City ______________ State ________ Zip ______

Cell Phone ______________________ Work Phone ______________________

Employer ______________________ Email ______________________

Orthodontic Insurance ☐ No ☐ Yes

Patient's Physician ______________________ Clinic ______________________

Have you been hospitalized in the last 5 years? ☐ No ☐ Yes Reason ______________________

Currently under a physician's care? ☐ No ☐ Yes Reason ______________________

Currently taking medications? ☐ No ☐ Yes

Drug and dosage ______________________

List all allergies ______________________

OVER

Has the patient ever had:

Condition	No	Yes
HIV/Aids	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Diabetes Type 1 (insulin controlled)	☐ No	☐ Yes
Diabetes Type 2 (diet controlled)	☐ No	☐ Yes
Epilepsy	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes
Sexually transmitted disease	☐ No	☐ Yes
Rheumatic fever	☐ No	☐ Yes
Heart murmur/Heart Surgery/Prolapse/ Pacemaker/Artificial valve	☐ No	☐ Yes
Are antibiotics required for dental work?	☐ No	☐ Yes
Joint replacement or implant	☐ No	☐ Yes
Are antibiotics required for dental work?	☐ No	☐ Yes
Abnormal bleeding/Blood disorder	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Angina (take nitroglycerin?)	☐ No	☐ Yes
Abnormal heart condition	☐ No	☐ Yes
Abnormal blood pressure ☐ high ☐ low	☐ No	☐ Yes
Chemical dependency (drugs, alcohol)	☐ No	☐ Yes
Tuberculosis	☐ No	☐ Yes
Women: are you pregnant?	☐ No	☐ Yes
Metal allergies	☐ No	☐ Yes
ADHD	☐ No	☐ Yes
Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Latex allergy	☐ No	☐ Yes
Cancer If yes, type: __________ ☐ Chemo ☐ Radiation	☐ No	☐ Yes
Celiac disease	☐ No	☐ Yes
Scarlet fever	☐ No	☐ Yes
Kidney disease	☐ No	☐ Yes
Liver disease	☐ No	☐ Yes
Thyroid disease	☐ No	☐ Yes
Hashimoto disease	☐ No	☐ Yes
Ulcers	☐ No	☐ Yes
Gastrointestinal disease	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Emphysema	☐ No	☐ Yes
Respiratory/airway disease	☐ No	☐ Yes

List other diseases, conditions or problems not listed above: ____________________

Describe any problems with your jaw:

Clicking? ____________________

Pain (joint, ear, side of face)? ____________________

Frequent headaches? ____________________

Difficulty in opening or closing? ____________________

Jaw ever locked or popped? ____________________

Clench or grind your teeth? ____________________

Have you ever had T.M.J. therapy? (please describe) ____________________

Signature ____________________ Date __________