RUCKER
ORTHODONTICS

Date: _____

NEW PATIENT REGISTRATION

Patient Information

Patient's Name: First _____ Last _____ Date of Birth: _____

Home Address: _____ # _____ City: _____ Zip: _____

Email: _____ Patient's School: _____

Accompanying Parent/Guardian: First _____ Last _____ Phone: (_____) _____-_____

Responsible Party Information

Person responsible for paying this account:

Name: First _____ Last _____ Date of Birth: _____

Home Address: _____ # _____ City: _____ Zip: _____

Own ◯ Rent ◯ How Long at this Residence: _____ Married ◯ Single ◯ Divorced ◯

Current Employer: _____ Occupation: _____ Years Employed: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ S.S.# _____

Email: _____ Relationship to Patient: _____

Medical History

Does the patient have or has the patient ever had:

	YES	NO		YES	NO
Heart Problems	◯	◯	Autism	◯	◯
Abnormal Blood Pressure	◯	◯	Cleft Lip/Palate	◯	◯
Anemia/Abnormal Bleeding	◯	◯	Diabetes	◯	◯
Asthma	◯	◯	Seizures/Epilepsy	◯	◯
Lung Disease/Tuberculosis	◯	◯	Frequent Headaches	◯	◯
Osteoporosis/Bone Disorder	◯	◯	Hepatitis	◯	◯
ADD/ADHD	◯	◯	HIV+/AIDS	◯	◯

Allergies to:

	YES	NO
Latex	◯	◯
Nickel	◯	◯
Local Anesthetic	◯	◯

Other: _____

_____

_____

Dental History

Does the patient have or has the patient ever had:

	YES	NO		YES	NO
Tooth Trauma or Injury	○	○	Oral surgery	○	○
Periodontal or "Gum Disease"	○	○	Use tobacco products	○	○
Pain in Jaw Joints or "TMD"	○	○	Has the patient ever been examined by an orthodontist	○	○
Pain or Soreness around your ear	○	○	Has any other family member been treated at this office	○	○
Difficulty or Pain while Chewing	○	○			

Dentist Name: _____ City _____ State _____

Which treatment method are you most interested in?

Braces ☐ Clear Braces ☐ Invisalign ☐ Lingual ☐

How Did you Hear About Us

Dental Provider ○	Internet Search ○	Walk-in ○
Dental Insurance ○	Facebook ○	Mailer ○
Family/Friend ○	Yelp! ○	Other: _____

Who may we thank for referring you to our office? _____

Dental Insurance Information

Primary Dental Insurance:

Policy Holder's Name: First _____ Last _____ Date of Birth: _____

Employer: _____ Insurance Company: _____ ID # _____

Secondary Dental Insurance:

Policy Holder's Name: First _____ Last _____ Date of Birth: _____

Employer: _____ Insurance Company: _____ ID # _____

I understand that the information I have given on this form is accurate and I am obligated to inform Dr. Rucker immediately of any future changes. I understand that where appropriate, credit reports ("soft inquiry") may be obtained. I authorize Dr. Rucker to provide my health care information to my other health care providers. I hereby consent to the making of diagnostic records, including x-rays, before, during, and following orthodontic treatment by Dr. Rucker and, where appropriate, staff providing orthodontic treatment as prescribed by Dr. Rucker.

_____ _____ _____

Printed Name of Patient (Parent/Guardian) Signature of Patient (Parent/Guardian) Date