Steven M. Lash, D.D.S., M.S., P.C.
Rebecca L. Rubin, D.M.D., M.S.

ADULT REGISTRATION

DATE:_____

NAME (Mr., Ms., Mrs., Dr.):_____ SEX:_____ AGE:_____

ADDRESS:_____CITY & ZIP:_____ HOME PHONE:_____

OCCUPATION/ EMPLOYER:_____ WORK PHONE:_____ CELL PHONE:_____

SPOUSE'S FULL NAME (Mr., Ms., Mrs., Dr.):_____

OCCUPATION/ EMPLOYER:_____ WORK PHONE:_____ CELL PHONE:_____

ANY PREVIOUS ORTHODONTIC TREATMENT OR CONSULTATION?_____

WHAT DO YOU WISH ORTHODONTIC TREATMENT TO ACCOMPLISH?_____

_____

NAME OF GENERAL DENTIST:_____ LOCATION:_____

NAME OF DENTAL INSURANCE:_____ ORTHODONTIC COVERAGE: YES NO

SUBSCRIBER ID #:_____ GROUP #:_____

WHO IS LEGALLY/ FINANCIALLY RESPONSIBLE?_____

WHOM MAY WE THANK FOR REFERING YOU?_____

MEDICAL HISTORY

DATE OF BIRTH:_____ DATE AND PURPOSE OF LAST MEDICAL EXAM:_____

HAVE YOU BEEN HOSPITALIZED IN LAST 5 YEARS?_____ IF YES, DESCRIBE:_____

ARE YOU CURRENTLY RECEIVING MEDICAL CARE?_____ IF YES, DESCRIBE:_____

ARE YOU TAKING ANY MEDICATIONS?_____ IF YES, DESCRIBE MEDICATION/ REASON:_____

IF ALLERGIC TO MEDICATION OR DRUGS, INDICATE WHICH ONES:_____

HAVE YOU EVER HAD ANY INFECTIOUS DISEASE?_____ IF YES, DESCRIBE:_____

HAVE YOU EVER BEEN DIAGNOSED AS HAVING TEMPOROMANDIBULAR JOINT DISORDER?_____

ANY PHYSICAL CONDITIONS OR HABITS?_____

NAME OF PHYSICIAN:_____ LOCATION:_____

THIS INFORMATION WAS GIVEN BY:_____

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