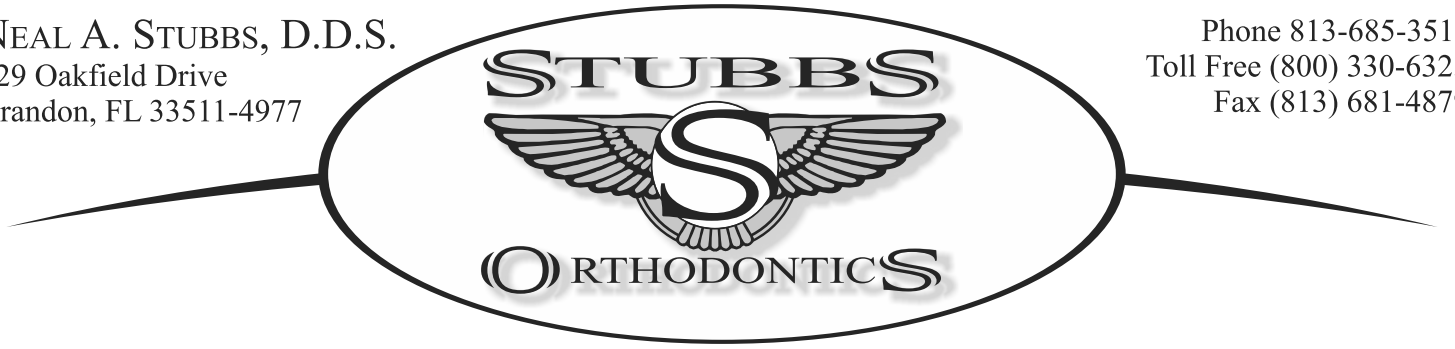
NEAL A. STUBBS, D.D.S.
929 Oakfield Drive
Brandon, FL 33511-4977



Phone 813-685-3511
Toll Free (800) 330-6325
Fax (813) 681-4879

NEW PATIENT REGISTRATION FORM

(FOR PATIENTS OVER AGE 18)

The information provided is strictly confidential.

PATIENT INFORMATION

Patient's Legal Name:_____ **Preferred Name:** _____

Today's date: ___/___/___ Birthdate: ____/____/____ Age:_____ Sex: M / F Marital Status: S / M / W / D

Address: _____ **City, State, Zip:** _____

Home phone: _(____)_____**Cell / Work:**_____

Email Address:_____

Social Security:_____ - _____ - _____ **Drivers License #:**_____

Employer:_____ **Occupation:**_____

Spouse's Name:_____

Home phone: _(___)_____ **Cell/Work #:** _(___)_____

Social Security:_____-_____-_____ **Drivers License #:** _____ **Birthdate:** ____/_____/_____

Employed by: _____ **Occupation:** _____ **Years:** _____

Brothers/Sisters or Sons/Daughters (name/ages):_____

Hobbies/Interests: _____

Previous orthodontic consultation? Yes / No If so, when/where? _____

In your opinion, what is your orthodontic problem? _____

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

_____

List all individuals authorized to access account information: _____

_____

_____

Do you have orthodontic insurance coverage? Yes / No If yes, please fill out insurance form. Thanks!
— Please complete both sides —

www.StubbsOrthodontics.com

DENTAL INFORMATION

How does the patient feel about wearing "braces": _____

Does anyone else in the family need orthodontics? Yes / No If yes who? _____

Dentist's Name: _____ **Does the patient have regular checkups? Yes / No**

Last Dental Exam: _____ **Last Dental X-Rays:**_____

Other Dental Specialists: _____

Have you been satisfied with past dentistry? Yes / No If no, please explain _____

_____

Does the patient currently have, or have had any of the following? (please circle)

Thumb/finger habit	Head/neck injury
Nail biting	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about? _____

_____

MEDICAL INFORMATION

Physician's Name: _____ **Patient's overall health: Excellent / Good / Poor**

Is the patient allergic to anything (drugs/food/pollen): _____

Is the patient currently under medical care? Yes / No Where/When? _____

_____

Is the patient currently taking medications? Yes / No Please list: _____

Has the patient ever been hospitalized? Yes / No Where/When? _____

Does the patient currently have, or have had any of the following? (please circle)

Adenoid removed	Drug history	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal/airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis A,B, or C	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal disease

EMERGENCY INFORMATION

Name:_____ **Relationship to patient:** _____
Address: _____ **City, State, Zip:** _____
Home Phone:_(___)_____ **Cell/Work #:** _(___)_____

***Signature:** _____ **Today's Date:** _____/_____/_____