



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. FIRST MIDDLE LAST MALE FEMALE

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

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?

Have you ever been diagnosed or treated for the following?

YES NO

- Heart Problems
Kidney Problems
Lung Problems
Liver Problems
Allergies
Diabetes
Epilepsy
Anemia
Arthritis

YES NO

- Hepatitis
Rheumatic Fever
Emotional Problems
Malignancies
Endocrine Problems
Bone Problems
Prolonged Bleeding
Tuberculosis
Asthma

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

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?
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?

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?

Are there any other dental/orthodontic problems I should be aware of?

Patient Signature Date