



Locations
7802 Timberlake Road - Lynchburg, VA 24502
1084 Thomas Jefferson Road - Forest, VA 24551

Phone: 434.385.GRIN (4746) | Fax: 434.237.6453
www.bracesbycvo.com

Patient Information

Date: _____
Patient's Last Name: _____ First Name: _____ Common Name: _____
Address: _____
Home #: _____ Cell #: _____ Email: _____
Birth date: _____ Age: _____ Sex: _____ Grade: _____ School: _____
Hobbies: _____ Who referred you: _____
Siblings & Age: _____
Has patient ever seen another orthodontist? Y / N Who? _____ Is this a second opinion? Y / N

Parent or Guardian Information (for patients under 18)

Patient lives with: __ Mother, __ Father, __ Step Mother, __ Step Father, __ Grandparent, __ Other

Parent/Guardian: _____ Home #: _____ Cell #: _____
Address (if different): _____
Employer: _____ Email: _____
Relationship to patient: _____ Birth date: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____
Address (if different): _____
Employer: _____ Email: _____
Relationship to patient: _____ Birth Date: _____

Dental Insurance

Do you have Medicaid? Yes / No

Primary Insured's Name: _____ SS#: _____
Birth Date: _____ Insurance Company: _____
Employer: _____ Group #: _____ ID #: _____

Secondary Insured's Name: _____ SS#: _____
Birth Date: _____ Insurance Company: _____
Employer: _____ Group #: _____ ID #: _____

Financial Responsibility

Who is financially responsible for this account: _____ Relationship to pt: _____
Address (if different): _____
Home #: _____ Cell #: _____ Email: _____
SS #: _____ Employer: _____

Additional Information

Patient's Dentist: _____ Date last seen: _____ Patient's Physician: _____
Name of other family members seen in our office: _____

Medical History

Drug allergies? Y/N List: _____

Latex/Rubber Gloves: Y/N Any Metals/Plastics: Y/N

Other: _____

List any medications patient is taking: _____

Has the patient ever taken intravenous bisphosphonates such as Zometa, Aredia or Didronel? Y/N

Has the patient ever taken oral bisphosphonates such as Fosomax, Actonel, Boniva, Skelid or Didronel? Y/N

Have you ever had any of the following medical issues?

Heart Attack / Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric / Learning Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High / Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy / Seizures / Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV+ / Aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia / Abnormal Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Surgery / Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer / Chemotherapy / Radiation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial Bones / Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus / Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adenoids / Tonsils Removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis (TB)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Has the patient ever had or been evaluated for Orthodontic treatment? Y/N

Has the patient ever had problems associated with any previous dental work? Y/N

Has the patient ever experienced pain, clicking or popping in the jaw joint? Y/N

Has the patient's jaw joint ever locked or felt like it was sticking? Y/N

Has the patient ever had an injury to the mouth/teeth/chin? Y/N

History of speech problems or speech therapy? Y/N

Does the patient play a musical instrument? Y/N

What concerns do you have about your / or your child's teeth _____

Who suggested that you/ or your child might need orthodontic treatment? _____

Authorizations

I authorize the release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

I certify that the above information is accurate and understand that an appropriate credit bureau report may be obtained.

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental history.

Signature: _____ Date: _____