CENTRAL VIRGINIA
ORTHODONTICS

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PATIENT INFORMATION

Date: _____

Patient's Last Name: _____ First Name: _____ Common Name:_____

Address: _____ City: _____ State: _____Zip:_____

Home #: _____ Cell #: _____ Email: _____

Birth Date: _____ Age: _____ Sex: F / M Grade: _____ School: _____

Hobbies: _____ Referred by: _____

Siblings & Age: _____

PARENT OR GUARDIAN INFORMATION (for patients under 18)

Patient lives with: ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other

Parent/Guardian: _____ Home #: _____ Cell #: _____

Address (if different):_____ City: _____ State: _____Zip:_____

Relationship to Patient: _____ Email: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____

Address (if different): _____

Relationship to Patient: _____ Email: _____

ADDITIONAL INFORMATION

Has patient ever seen orthodontist? Y / N Name: _____ Is this a second opinion? Y / N

Patient's Dentist: _____ Date last seen: _____

Patient's Physician: _____

Name of other family members seen in our office: _____

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

How did you first hear about our office?_____

Primary Responsible Party

Person financially responsible for this account:_____ Relationship to patient:_____

Address (if different): _____ City: _____State: _____ Zip:_____

Years at this address:_____ Own/Rent Residence: _____ Birth Date_____

SS #:_____ Cell #: _____ Email: _____

Occupation: _____Years at Current Employer: _____

Secondary Responsible Party

Person financially responsible for this account:_____ Relationship to patient:_____

Address (if different): _____ City: _____State: _____ Zip:_____

Years at this address:_____ Own/Rent Residence: _____ Birth Date_____

SS #:_____ Cell #: _____ Email: _____

Occupation: _____Years at Current Employer: _____

Dental Insurance

Do you have Medicaid? Y/N

Primary Insured's Name: _____ SS #: _____

Birth Date: _____ Insurance Company: _____

Employer: _____ Group #: _____ ID #: _____

Primary Insured's Name: _____ SS #: _____

Birth Date: _____ Insurance Company: _____

Employer: _____ Group #: _____ ID #: _____

Medical History

Current Medications, if any:		
Drug or other allergies? List: _____	☐ Y	☐ N
Allergies to Latex / Rubber Gloves / Metals / Plastics? (circle which if answer is yes)	☐ Y	☐ N
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
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

Has the patient ever had any of the following medical issues?

Heart Attack / Stroke	☐ Y	☐ N	Psychiatric / Learning Problems	☐ Y	☐ N	Asthma	☐ Y	☐ N
High / Low Blood Pressure	☐ Y	☐ N	Epilepsy / Seizures / Fainting Spells	☐ Y	☐ N	Adenoids / Tonsils Removed	☐ Y	☐ N
Diabetes	☐ Y	☐ N	Heart Murmur	☐ Y	☐ N	Arthritis	☐ Y	☐ N
Rheumatic Fever	☐ Y	☐ N	HIV+ / Aids	☐ Y	☐ N	Sinus / Breathing Problems	☐ Y	☐ N
Hemophilia / Abnormal Bleeding	☐ Y	☐ N	Heart Surgery / Pacemaker	☐ Y	☐ N	Hepatitis	☐ Y	☐ N
Cancer / Chemotherapy / Radiation	☐ Y	☐ N	Mitral Valve Prolapse	☐ Y	☐ N	Tuberculosis (TB)	☐ Y	☐ N
Kidney Problems	☐ Y	☐ N	Artificial Bones / Joints	☐ Y	☐ N			

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 (Patient or Parent/Guardian): _____ Date: _____