

VALLEY ORTHODONTICS

Patient Information

Date _____
Patient's Name _____ School _____
Address _____
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____ Dentist _____

Responsible Party Information

Name _____
Residence _____
Mailing Address _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs.) _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insurance I.D. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes No If yes: Phone # _____
Insured's Name _____ Insurance I.D. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Continued on back

Health Questionnaire

Please answer each question. Circle Yes or No where applicable.

MEDICAL HISTORY

1. Is the patient in good health?Yes No
2. Is the patient presently under the care of a physician?Yes No
If so, what is the condition being treated? _____
3. Has the patient ever had any serious illness or operation?Yes No
If yes, what? _____
4. Is the patient sensitive or allergic to any drugs?Yes No
If yes, please indicate which drugs: _____
5. Is the patient taking any drugs or medication?Yes No
If yes, what? _____
6. Does the patient have tendency to colds, sore throats, or ear infections?Yes No
7. Has the patient reached puberty?Yes No
Menstruated (girls) age: _____ or voice changed (boys) age: _____
8. Does the patient have any of the following: (Please circle known conditions)

- | | | | |
|----------------------------|--------------------------------------|--------------------------|------------------|
| Anemia | Blood Diseases | Rheumatism or Arthritis | Epilepsy |
| Heart Ailments | Hepatitis, Jaundice or Liver Disease | Head Injuries | Mental Disorders |
| High or low blood pressure | Kidney Disease | Stomach Ulcers | Stroke |
| Respiratory | Tumors or Growths | Difficulty in swallowing | Glaucoma |
| Tuberculosis | Radiation Treatment of any kind | Venereal Disease | Herpes |
| Nervous Disorders | Allergies | AIDS, ARC or HIV virus | Sinus Trouble |
| Diabetes | Asthma or Hay Fever | Other _____ | |
| Excessive Bleeding | Fainting spells or seizures | | |
| Rheumatic Fever | Artificial Prosthesis (Implants) | Pregnant (now) | |

9. Does the patient have any disease, condition, or problem not listed that you think I should know?Yes No
If yes, what? _____

Family Physician: _____

DENTAL HISTORY

1. Date of last dental examination? _____
2. Is dental work complete?Yes No
3. How often does the patient brush teeth? _____ Floss? _____
4. Has Patient ever had an injury to face or jaw?Yes No
If yes, what? _____
5. Is the patient aware of tooth grinding or clenching habits?Yes No
6. Does the patient have any speech problems?Yes No
7. Does the patient breath mostly through the mouth?Yes No
8. Has the patient ever sucked a thumb or finger?Yes No
If yes, until what age? _____
9. Does the patient smoke or chew tobacco?Yes No
10. Does orthodontic/dental treatment make the patient nervous?Yes No
11. Does the patient's jaw make "clicking" or "popping" sounds when chewing?Yes No