PATIENT INFORMATION

Patient's Name____ Nickname___________________ Birthdate ______________ ____ Male ☐ Female ☐
Address____City__________________________State______Zip___________________
Home Phone______________________ Work Phone__________________________ Cell______________________ SS#________________________________
Email address____
If patient is a minor, give custodial parents or legal guardian's name____
Names of family members who are orthodontic patients here____
Whom may we thank for referring you to our office____

PERSON RESPONSIBLE FOR THIS ACCOUNT

Marital Status: ☐☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Spouse Name ____
Name____Email____
Address____
Mailing Address____
Home Phone____ Work____ Cell____________________________
SS#____________________________ Birthdate____________________________Relationship to Patient____

PATIENT'S SPOUSE OR OTHER PARENT

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single Spouse Name ____
Name____Email____
Address____
Mailing Address____
Home Phone____ Work____ Cell____________________________
SS#____________________________ Birthdate____________________________Relationship to Patient____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company_______________________________ Subscriber's Name______________________________________Subscriber's Birthdate______________
Employer______________________________Address____Phone____________________________
Group #_____________________________ Subscriber ID or SS#________________________________Insurance Phone #________________________________

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company_______________________________ Subscriber's Name______________________________________Subscriber's Birthdate______________
Employer______________________________Address____Phone____________________________
Group #_____________________________ Subscriber ID or SS#________________________________Insurance Phone #________________________________

Emergency Contact

Emergency Contact____ Phone___________________________
Relationship to patient____

PAYMENT OF PROFESSIONAL FEES

Payment at the time of services is expected. For your convenience, we accept VISA and MASTERCARD. Our office will be happy to submit claims to your insurance company. A service charge of 1 ½% per month will be added to all balances 60 days and older. The annual rate of the service charge is 18%.

I understand that Virginia Family Dentistry, P.C. will make every effort to collect from my insurance company. I hereby authorize Virginia Family Dentistry, P.C. to furnish information to insurance carriers concerning my treatment and I hereby assign to the dentist all payments for dental services rendered to me or my dependents. By signing this form, I acknowledge and understand that I am responsible for any amounts not covered by insurance for services rendered to me or my dependents. I also acknowledge and understand that if the account is turned over to an attorney for collection, I hereby agree to pay thirty percent (30%) attorney or collection agency fees on the unpaid balance.

Date_______________________________ Signature____

MEDICAL HISTORY

Patient____

Physician____City_____________________________Phone_____________________________

Does the patient:

Yes	No	
☐	☐	Have any health problems? Explain____
☐	☐	Take any medications? List____
☐	☐	Have allergic reactions to medications? List____
☐	☐	Currently see a physician? Explain____
☐	☐	Had their tonsils and adenoids removed? When____
☐	☐	Take medications for osteoporosis or other bone disorders (e.g. biophosphates?) List ________________________________
☐	☐	Have an allergic reaction to latex?
☐	☐	Have an allergic reaction to metal (jewelry or clothing snaps)?

Please check if **patient** has (currently or in the past) had any of the following conditions:

	Yes	No		Yes	No		Yes	No
Heart Murmur	☐	☐	Hives/Rash	☐	☐	Autism/Asperger's	☐	☐
Heart Surgery	☐	☐	Diabetes	☐	☐	Frequent Headaches	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	ADD/ADHD	☐	☐
High Blood Pressure	☐	☐	Liver Disease/Hepatitis	☐	☐	Cancer	☐	☐
Prolonged Bleeding	☐	☐	Tuberculosis	☐	☐	Bone Disorders	☐	☐
Anemia	☐	☐	Bronchitis	☐	☐	Growth Disorders	☐	☐
Blood Disease	☐	☐	Asthma	☐	☐	Herpes (Fever Blisters)	☐	☐
Endocrine Disorders	☐	☐	Epilepsy/Seizures	☐	☐	Arthritis/Rheumatism	☐	☐
Developmental Disorder	☐	☐	Fainting	☐	☐	Currently Pregnant	☐	☐
HIV/AIDS	☐	☐				If pregnant,due? __________		

Any other conditions or problems that we should know about (e.g. Nervous, anxious, emotional problems)? _________________________________

Growth information for patients under 16 – Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid our treatment alternatives: Has Patient:

Reached puberty	☐ Yes	☐ No	
Girls – started menstruation?	☐ Yes	☐ No	When?____
Boys – voice changed?	☐ Yes	☐ No	When?____
Do you feel growth is completed?	☐ Yes	☐ No	Father's Height___________Mother's Height__________
Have siblings or parents been treated with orthodontics?	☐ Yes	☐ No	

DENTAL HISTORY

Current Dentist____City____

Are you or your child sensitive or self-conscious about your teeth or smile? ☐ Yes ☐ No

What is your chief concern with your (or your child's) teeth?____

Frequency of dental checkups: Twice a yr ☐ Once a yr ☐ Only if problem exists ☐ Never ☐ Date of last visit______________

Is there any unfinished care to be complete with your dentist?	☐ Yes	☐ No	Explain:____
Are you frightened about dental treatment?	☐ Yes	☐ No	Explain:____
Have you had any face or dental injuries?	☐ Yes	☐ No	Explain:____
Do you play any musical instrument?	☐ Yes	☐ No	What instrument?__________________________________
Have you consulted with an orthodontist previously?	☐ Yes	☐ No	With whom?_______________________________________
Have teeth (either primary or permanent) been removed?	☐ Yes	☐ No	Explain:____
Have you had any previous orthodontic treatment?	☐ Yes	☐ No	With whom?_______________________________________
Are you satisfied with prior treatment?	☐ Yes	☐ No	Explain:____
Is there a history of thumb or finger sucking?	☐ Yes	☐ No	How long:____
Do you have supernumerary (extra) or congenitally missing teeth?	☐ Yes	☐ No	Explain:____

Please check if there is a history of:

☐ Clenching teeth ☐ Muscular soreness around head and neck ☐ Jaw joint soreness ☐ Jaw joint popping

☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in ears

☐ Speech problems (If so, what sounds?______________________________) ☐ Mouth breathing (circle): awake asleep

☐ Difficulty in chewing ☐ Periodontal or gum treatment (If so, Explain____)

I have read and understand the above questions. 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. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Patient's Signature____________________________________Parent/Guardian Signature (if minor)________________________________Date_________________