



W. Gray Grieve, D.D.S., M.S.
Valley River Orthodontic Center

WELCOME TO OUR OFFICE

(kindly complete this page in black ink & bring to your complimentary exam)

Acct# _____
Model# _____

PATIENT INFORMATION:

Name: _____ Sex: (M) (F) Likes to be called: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ ok to call? _____
Birthdate: _____ Age: _____ Grade: _____ School: _____ Referred by: _____
Hobbies & Interests: _____

RESPONSIBLE PERSON INFORMATION:

Name: _____
Address: _____
City: _____ Zip: _____ # Years: _____
Home: _____ Cell: _____
Email: _____ Fax: _____
Relationship to patient: _____
Social Security #: _____ Marital Status: _____
Birthdate: _____
Employer: _____ # Years _____
Occupation: _____ Wk Phone: _____
Person to contact in case of emergency: _____

Name: _____
Address: _____
City: _____ Zip _____ # Years _____
Home: _____ Cell: _____
Email: _____ Fax: _____
Relationship to patient: _____
Social Security #: _____ Marital Status: _____
Birthdate: _____
Employer: _____ # Years _____
Occupation: _____ Wk Phone: _____

Name Phone# Address

FAMILY INFORMATION:

With whom does the patient live: _____
Other adults we should know about:
Name: _____ Relationship to Patient: _____
Home: _____ Cell: _____ Wk: _____
Name: _____ Relationship to Patient: _____
Home: _____ Cell: _____ Wk: _____
Name: _____ Relationship to Patient: _____
Home: _____ Cell: _____ Wk: _____

Names and ages of any brothers and sisters:

Other family members and friends seen in our office:

Other family members who have had orthodontic treatment:

DENTAL INSURANCE INFORMATION:

Policy Holder's Name: _____
Social Security/ID #: _____
Birthdate: _____
Employer: _____
Insurance Company: _____
Insurance Address: _____
Phone#: _____
Group Name or Number: _____

If dual coverage, which is primary: _____
Insured Name: _____
Social Security/ID #: _____
Birthdate: _____
Employer: _____
Insurance Company: _____
Insurance Address: _____
Phone#: _____
Group Name or Number: _____

Patient: _____

Patient Health History

Physician: _____ Phone: _____ Date of last exam: _____

Please indicate any of the following conditions that apply to our patient, now or in the past:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
ADD	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to metals: _____	<input type="checkbox"/>	<input type="checkbox"/>	Hyperkinetic	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to latex or rubber: _____	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant (currently)	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent eye/ear/neck/headache	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems: _____	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	TMJ (see separate form)	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>

Any illness or physical problems we should know? YES NO If yes, please explain: _____

OTHER: _____ Current Medications: _____

Patient Dental History

Dentist: _____ Phone: _____ Date of last exam/cleaning: _____

Please indicate any of the following conditions that apply to you/your child now or in the past:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Gums bleed while brushing/flossing?	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to hot/cold liquid/food?	<input type="checkbox"/>	<input type="checkbox"/>	Any teeth injured/loosened by a fall/blow?	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitive to sweet/sour liquid/food?	<input type="checkbox"/>	<input type="checkbox"/>	Any sores/lumps in/near the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Any head, jaw, or spinal injuries?	<input type="checkbox"/>	<input type="checkbox"/>
Ever experienced any of the following problems in your jaw?			Grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	Bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	Ever had any extractions?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	Had any orthodontic consultations?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	Had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
			Does this patient like their smile?	<input type="checkbox"/>	<input type="checkbox"/>

Any dental concerns we should know? _____ If yes, please explain: _____

Main Concern:

Your main reasons for seeking treatment:

alignment crossbite crowding gum disease headaches jaw-related pain missing teeth protruding teeth overbite underbite TMJ
 other: _____

Your concerns regarding orthodontics: _____

I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment; I understand that a credit bureau check may be obtained where necessary.

Date: _____

Signature: _____