## "Get to Know You" Form

## We are very happy to have you join our practice. WELCOME!

For Dr. Grieve, orthodontic treatment is more than a great plan and excellent care. Dr. Grieve wants to get to know you and your family. The better we know each other, the more you will learn about your treatment. We hope you look forward to your appointments as much as we look forward to seeing you!

## Please, help us get to know you better:

What is your name?	How old are you?
What school do you attend?	
If you have brothers & sisters, what are their names	s?
What do you do for fun?	
Do you like or play any sports, musical instruments?	
Do you have any pets?	
Any great news that you'd like to share with us?	
What do you want to be when you grow up?	
What do you think about getting some of Dr. Griev	

If you wish, please share a photo of you or your family here



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

Insurance Address:

Phone#:

Group Name or Number: \_\_\_\_\_

## WELCOME TO OUR OFFICE Acct#

ICL	ACCI#
nlimentary exam)	Model#

(kindly complete this page in black ink & bring to your complimentary exam) Model#\_\_\_\_\_ **PATIENT INFORMATION:** \_\_\_\_\_ Sex: (M) (F) Likes to be called: \_\_\_\_\_ \_\_\_\_\_\_ City: \_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_ Address: \_\_\_ Home Phone: \_\_\_\_\_\_ Ok to call?\_\_\_\_ 
 Birthdate:
 \_\_\_\_\_\_ Age:
 \_\_\_\_\_ School:
 \_\_\_\_\_ Referred by:
 Hobbies & Interests: **RESPONSIBLE PERSON INFORMATION:** Name: Address:\_\_\_\_ Address: City: Zip # Years City: Zip: # Years: Home: Cell: Home: Cell: Email: Fax:\_\_\_\_\_ Email:\_\_\_\_\_ \_Fax:\_\_\_ Relationship to patient: Relationship to patient: Social Security #: Marital Status: Social Security #: Marital Status: Birthdate: Birthdate: Employer:\_\_\_\_\_\_# Years\_\_\_\_\_ Employer:\_\_\_\_\_ # Years Occupation: Wk Phone: Occupation: \_\_\_\_\_Wk Phone: \_\_\_\_ Person to contact in case of emergency: Phone# Address **FAMILY INFORMATION:** With whom does the patient live: Names and ages of any brothers and sisters: Other adults we should know about: \_\_\_\_\_Relationship to Patient:\_\_\_\_ Name: Home: Cell: Wk: Other family members and friends seen in our office: Name: Relationship to Patient: Home: \_\_\_\_\_ Cell: \_\_\_\_ Wk:\_\_\_ Name: \_\_\_\_\_\_ Relationship to Patient:\_\_\_\_\_ Other family members who have had orthodontic treatment: Home: Cell: **DENTAL INSURANCE INFORMATION:** If dual coverage, which is primary: Policy Holder's Name: Insured Name: Social Security/ID #: \_\_\_\_ Social Security/ID #: Birthdate: Birthdate: Employer:\_\_\_\_ Employer: Insurance Company:\_\_\_\_\_ Insurance Company:\_\_\_\_\_

Insurance Address:

Phone#:

Group Name or Number: \_\_\_\_\_

Patient:					
Dationt Haalth History					
Patient Health History					
Physician:	Pho	ne:	Date of	last exam	ı:
Please indicate any of the following conditions that apply to our pa	tient	t, now	or in the past:		
ADD		<u>No</u> □	Glaucoma	<u>Yes</u>	<u>No</u> □
ADHD			Heart trouble		
Arthritis			Hemophilia		
AIDS or HIV positive			Hepatitis		
Allergic to metals:			Hyperkinetic Pregnant (currently)		
Allergies/other:		П	Psychotherapy		
Asthma			Recurrent eye/ear/neck/headache		
Bleeding problems:	□		Rheumatic Fever		
Depression			TB		
Diabetes Enilopsy			TMJ (see separate form) Ulcer		
Epilepsy	П		Oicei		
ny illness or physical problems we should know? □ YES □ NO	If ye	es, plea	ase explain:		
OTHER:	Curr	rent Me	edications:		
Dentist: Phone:Phone:Phone:				<sup>/</sup> cleaning:	
, , , , , , , , , , , , , , , , , , ,				V	o No
Gums bleed while brushing/flossing?		<u>No</u> □	Frequent headaches?		<u>es</u> <u>No</u> □ □
Teeth sensitive to hot/cold liquid/food?			Any teeth injured/loosened by a fall/blow? Any sores/lumps in/near the mouth? Any head, jaw, or spinal injuries?	С	
Teeth sensitive to sweet/sour liquid/food?			Any sores/lumps in/near the mouth?		
Feel pain to any of your teeth?			Any head, jaw, or spinal injuries?		
Ever experienced any of the following problems in your jaw? Clicking			Grind or clench your teeth? Bite your lips or cheeks frequently?		]
Pain (joint, ear, side of face)			Ever had any extractions?		
Difficulty opening or closing			Had any orthodontic consultations?		
Difficulty chewing			Had any orthodontic treatment?		1 🗆
			Does this patient like their smile?		
any dental concerns we should know? If yes, please explair	1:				
Main Concern:					
our main reasons for seeking treatment:					
alignment □ crossbite □ crowding □ gum disease □ headaches □	iaw	relator	I nain missing teeth protruding tooth p	overhito	Underhite - TMI
a other:	-				underbite - HVIS
our concerns regarding orthodontics:					_
attest to the accuracy of this information and acknowledge	ae ti	hat it :	is my responsibility to notify this office	of anv	medical or conta
changes; I authorize release of any information to a third	-	y IUF I	msurance ciaims, education, and/or tr	ะสนาเ <del>ย</del> กใ	., i understand tr
a credit bureau check may be obtained where necessary.					
Date: Sign:	atur	re:			