"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?_____ What grade?_____

If you have brothers & sisters, what are their names?_____

_____

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. Grieve's AWARD WINNING braces?

_____

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

Please bring this form to your first appointment, thank you!

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: _____

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 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:

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

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:

	Yes	No		Yes	No
Gums bleed while brushing/flossing?	□	□	Frequent headaches?	□	□
Teeth sensitive to hot/cold liquid/food?	□	□	Any teeth injured/loosened by a fall/blow?	□	□
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?			Grind or clench your teeth?	□	□
Clicking	□	□	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?	□	□
			Does this patient like their smile?	□	□

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:** _____