



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: _____