VALLEY ORTHODONTICS

Date

PATIENT INFORMATION

Patient's Last Name	First	Middle	Home Phone
Address		Birth date / /	Age	Sex ☐ M ☐ F
City	State	ZIP Code
Dentist	Whom may we thank for referring you to our office?

If Patient is under 18 years of age please fill out the following questions.

Parent's or Guardian's Names	School

RESPONSIBLE PARTY INFORMATION

Last Name	First	Middle	Marital Status
Physical Address:			
Mailing Address:			
How long at this address?	Home Phone	Work Phone	Cell Phone
Previous Address (if less than 3 years)			
Primary Email	Secondary Email		
Social Security Number	Birth date / /	Relationship to Patient	
Employer	Occupation	Years Employed	
Spouse's Last Name	First	Middle	Relationship to Patient
Employer	Occupation	Years Employed	
Social Security Number	Birth date / /	Home Phone	Work Phone	Cell Phone

INSURANCE INFORMATION

Subscriber's Name	Primary Insurance I.D. Number	
Primary Insurance Company	Group Number	Subscriber's Date of Birth
Primary Insurance Company Address		
Primary Insured's Employer	Primary Insurance Company Phone Number	
Subscriber's Name	Secondary Insurance I.D. Number	
Secondary Insurance Company	Group Number	Subscriber's Date of Birth
Secondary Insurance Company Address		
Secondary Insured's Employer	Secondary Insurance Company Phone Number	

CERTIFICATION OF ACCURACY

The above information is true to the best of my knowledge. I understand that where appropriate, credit bureau reports may be obtained. I authorize my insurance benefits be paid directly to Valley Orthodontics. I understand that I am financially responsible for any balance. I also authorize Valley Orthodontics or my insurance company to release any information required to process my claims.

Patient/Guardian Signature   *Date*

VALLEY ORTHODONTICS
Health Questionnaire

Please answer each question regarding the patient. Check Yes or No where applicable.

DENTAL HISTORY

	YES	NO
Physician		
1. Date of last dental examination?		
2. Is dental work complete?	☐	☐
3. How often do you brush your teeth? Floss?		
4. Have you ever had an injury to your face or jaw?	☐	☐
5. Are you aware of tooth grinding or clenching habits?	☐	☐
6. Do you have speech problems?	☐	☐
7. Do you breathe mostly through your mouth?	☐	☐
8. Does orthodontic/dental treatment make you nervous?	☐	☐
9. Does your jaw make a “clicking” or “popping” sound when you chew?	☐	☐
10. Have you ever sucked a thumb or finger? Until what age?		

MEDICAL HISTORY

	YES	NO
Are you in good health?	☐	☐
1. Are you presently under the care of a physician?	☐	☐
If so, what is the condition being treated?		
2. Have you ever had any serious illnesses or operation?	☐	☐
If so, please list		
3. Are you taking any drugs or medication?	☐	☐
If so, please list		
4. Are you sensitive or allergic to any drugs?	☐	☐
If so, please list		
5. For minors, has the patient reached puberty?	☐	☐
Menstruated at Age Voice Changed at Age		
6. Do you have a tendency to colds, sore throats, or ear infections?	☐	☐
7. Have you had your tonsils or adenoids removed?	☐	☐
8. Have you been exposed to or tested positive to HIV?	☐	☐
9. Do you have, or have you had any of the following?	☐	☐

☐ Anemia	☐ Blood Diseases	☐ Rheumatism or Arthritis
☐ Heart Ailments	☐ Hepatitis, Jaundice or Liver Disease	☐ Head Injuries
☐ High Blood Pressure	☐ Kidney Disease	☐ Stomach Ulcers
☐ Respiratory	☐ Tumors or Growths	☐ Difficulty in Swallowing
☐ Tuberculosis	☐ Radiation Treatment of any kind	☐ Venereal Disease
☐ Nervous Disorders	☐ Allergies	☐ Acquired Immune Deficiency
☐ Diabetes	☐ Asthma or Hay Fever	☐ Epilepsy
☐ Excessive Bleeding	☐ Fainting Spells or Seizures	☐ Mental Disorders
☐ Rheumatic Fever	☐ Artificial Prosthesis (Implants)	☐ Stroke
☐ Glaucoma	☐ Herpes	☐ Sinus Trouble

	YES	NO
10. Do you have any disease, condition or problem not listed?	☐	☐
If so, please list		

IN CASE OF EMERGENCY

Name of nearest relative not living with you	Relationship to Patient	
Complete Address	Home Phone	Cell Phone