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:**________________________________