ASHBY orthodontics
Owens ▪ Dorfman

B/N/C R/W/Y/N

PATIENT INFORMATION

DATE: / / ***Welcome to Our Office***

Last Name	First Name	Please Call Me	Sex M/F	Birth Date / /	Age

Mailing Address	City	State	Zip Code	Home Phone

Dentist's Name	Whom may we thank for referring you?

Additional Patient Information for our Adult Patients

Employer	Employer Phone	SSN	Email Address

Spouse's Name	Birth Date / /	Employer	SSN

Additional Patient Information for our Minor Patients

School	Grade	Hobbies

Parent/Guardian Information for our Minor Patients

Mother/Guardian's Name _____

Address (if different than Patient's) _____

_____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ SSN _____

Employer _____ Address _____

City _____ State _____ Zip _____

Email Address _____

Father/Guardian's Name _____

Address (if different than Patient's) _____

_____

City _____ State _____ Zip _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ SSN _____

Employer _____ Address _____

City _____ State _____ Zip _____

Email Address _____

Patient resides with:

Primary Orthodontic Insurance Information

Insurance Co. Name _____ Phone # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth Date _____ SSN _____

Insured's Employer _____

Secondary Orthodontic Insurance Information

Insurance Co. Name _____ Phone # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth Date _____ SSN _____

Insured's Employer _____

Person Responsible for Account

Name	Relationship to Patient	Home Phone	Cell Phone

Billing Address	City	State	Zip

SSN	Email	Employer	Work Phone

With whom may we discuss account information?

ASHBY orthodontics
Owens ▪ Dorfman

4356-4 Bonney Road, Virginia Beach, VA 23452

1021 North Eden Way, Suite 128, Chesapeake, VA 23320

7400 Granby Street, Norfolk, VA 23505

Medical History

Please circle Yes or No if patient has or has had

[Y] [N] Joint Swelling
[Y] [N] Bone Disorders
[Y] [N] Heart Trouble
[Y] [N] Mitral valve prolapse
[Y] [N] Is pre-med necessary?
[Y] [N] Rheumatic trouble
[Y] [N] Thyroid problems
[Y] [N] Diabetes
[Y] [N] Emotional problems
[Y] [N] Brain injury
[Y] [N] Kidney or liver involvement
[Y] [N] Joint prosthesis
[Y] [N] Tuberculosis
[Y] [N] Anemia
[Y] [N] Epilepsy (convulsions)
[Y] [N] Prolonged bleeding
[Y] [N] Faintness/Dizziness
[Y] [N] Tonsils removed
[Y] [N] Adenoids removed
[Y] [N] Sore throats
[Y] [N] Tonsillitis
[Y] [N] Earaches
[Y] [N] Arthritis

On items checked "Yes", please provide us with a more detailed description.

_____

_____

_____

Dental History

Please circle Yes or No

[Y] [N] Any injuries to face, mouth, teeth?
[Y] [N] Thumb, finger, lip sucking?
[Y] [N] More than average amount of decay?
[Y] [N] Any missing permanent teeth?
[Y] [N] Any teeth removed by extraction?
[Y] [N] Any difficulty in swallowing or chewing?
[Y] [N] Any pain or clicking on opening mouth?
[Y] [N] Is patient adopted? At what age? _____
[Y] [N] Does patient visit dentist regularly? Date of last visit: _____
[Y] [N] Has an orthodontist been consulted previously?
What would you like to have orthodontic treatment accomplish?

_____

_____

_____

_____

Approximately how much has patient grown in the last year?

List any other serious illnesses:

List any allergies:

List drugs or medication now being taken:

Is patient presently under physician's care? If yes, reason?

Name of physician:
Primary: Other:

Patient's attitude toward orthodontic treatment:
(circle one) Very motivated Will cooperate if needed Not motivated

Adolescent Females: Has menstruation begun? [Y] [N]
Date (month / year)

To the best of my knowledge, the above information is complete and correct. I give my permission for the use of orthodontic records, including photographs and video, made in the process of examinations, treatment, and retention for the purposes of professional consultations, research, education, or publication in professional journals. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____ _____

Date Signature of Patient or Parent or Gaurdian if Patient is a Minor