

**Dr. John O. Ashby**

**Dr. Curtis W. Dailey**

**(757) 340-7000**

***www.TidewaterOrthodontics.com***

***Patient Information***

Sex

SS #

Nickname

First Name

Last Name

Birth date

/ /

Age

City

Mailing Address

State

Zip Code

Home Phone #

Cell Phone #

Business Phone #

Employed By/Occupation

[ ] Single [ ] Married

[ ] Sep [ ] Divorced

[ ] Widow(er)

Grade

Father/ Guardian’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from Patient’s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

S.S. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Mother/ Guardian’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from Patient’s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

S.S. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_

***Please complete ( if patient is a minor)***

***Secondary Orthodontic Insurance Information***

***Primary Orthodontic Insurance Information***

Insurance Co. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # \_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Co. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone # \_\_\_\_\_\_\_\_\_\_\_

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S.S.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Person Responsible for Account***

Cell Phone #

Home Phone #

Relationship to Patient

Name

Billing Address

City

State

Zip

Work Phone #

Employer

E-mail

S.S. #

2.

2.

1.

1.

Names and ages of other children

Related Patients that are or have been under our care

Who may we thank for recommending us?

Name of Dentist/ Office Location

Date of Last Visit

E-mail

School (if Student)



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***Medical History***

***Dental History***

*Please circle Yes or No if patient has or has had*

[ Y ] [ N ] Joint swelling [ Y ] [ N ] Tuberculosis

[ Y ] [ N ] Bone disorders [ Y ] [ N ] Anemia

[ Y ] [ N ] Heart trouble [ Y ] [ N ] Epilepsy (convulsions)

[ Y ] [ N ] Mitral valve prolapse [ Y ] [ N ] Prolonged bleeding

[ Y ] [ N ] Rheumatic trouble [ Y ] [ N ] Faintness/Dizziness

[ Y ] [ N ] Thyroid problems [ Y ] [ N ] Tonsils removed

[ Y ] [ N ] Diabetes [ Y ] [ N ] Adenoids removed

[ Y ] [ N ] Emotional problems [ Y ] [ N ] Sore throats

[ Y ] [ N ] Brain injury [ Y ] [ N ] Tonsillitis

[ Y ] [ N ] Kidney or liver involvement [ Y ] [ N ] Earaches

[ Y ] [ N ] Joint prosthesis [ Y ] [ N ] Arthritis

**On items checked “Yes,” please provide us with a more detailed description:**

*Please circle Yes or No*

[ Y ] [ N ] Any injuries to face, mouth, teeth? (circle)

[ Y ] [ N ] Thumb, finger, lip sucking? (circle)

[ 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 the dentist regularly? Date of last visit \_\_\_\_\_\_\_\_\_\_\_

[ Y ] [ N ] Has an orthodontist been consulted previously?

**Reason:**

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 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 Guardian if Patient is a Minor

Adolescent Females: Has menstruation begun? [ Y ] [ N ]

Date ( month/ year )

Patient’s attitude toward orthodontic treatment:

(circle one) Very motivated Will cooperate if needed Not motivated

Name of physician:

Primary: Other:

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

List drugs or medication now being taken:

List any allergies:

List any other serious illnesses:

What would you like to have orthodontic treatment accomplish?

Have you or any member of your family or close relative had:

Rheumatoid arthritis? [ Y ] [ N ] Lupus? [ Y ] [ N ]

Approximately how much has patient grown in the last year?