TIDEWATER
ORTHODONTICS

Dr. John O. Ashby

Dr. Curtis W. Dailey

(757) 340-7000

www.TidewaterOrthodontics.com

Patient Information

Last Name	First Name	Nickname	SS #	Sex	Birth date / /	Age

Mailing Address	City	State	Zip Code	Home Phone #

School (if Student)	Grade	[ ] Single [ ] Married [ ] Sep [ ] Divorced [ ] Widow(er)	Employed By/Occupation	Business Phone #	Cell Phone #

E-mail	Who may we thank for recommending us?	Name of Dentist/ Office Location	Date of Last Visit

Related Patients that are or have been under our care	Names and ages of other children
1.	1.
2.	2.

Please complete (if patient is a minor)

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 _____

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 _____

Primary Orthodontic Insurance Information

Insurance Co. Name _____Phone # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth Date _____ S.S.# _____

Insured's Employer _____

Secondary Orthodontic Insurance Information

Insurance Co. Name _____Phone # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth Date _____ S.S.# _____

Insured's Employer _____

Person Responsible for Account

Name	Relationship to Patient	Home Phone #	Cell Phone #

Billing Address	City	State	Zip

S.S. #	E-mail	Employer	Work Phone #

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Medical 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:

Dental History

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:

Approximately how much has patient grown in the last year?

Have you or any member of your family or close relative had:
Rheumatoid arthritis? [Y] [N] Lupus? [Y] [N]

What would you like to have orthodontic treatment accomplish?

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 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