

Dr. John O. Ashby

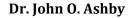
Dr. Curtis W. Dailey

(757) 340-7000

Patient Information

www.TidewaterOrthodontics.com

Last Name		First Na	First Name			name	SS#	Sex	Birth date	Age	
		1				Lac	<u> </u>		/ /	\perp	
Mailing Address			City		State	State Zip Code Home Phone		me Phone #			
School (if Student)	(if Student) Grade [] Single [] Marrie [] Sep [] Divorce [] Widow(er)						Business Phone	e# Cell Phone #			
			ho may we thank for recommending			ng us? Name of Dentist/ Office Location Date of Last Visit			isit		
Related Patients that are or have been under our care					Names and ages of other children						
1.					1.						
2.					2.						
Please complete (i	f patient is	a mino	r)								
Mother/ Guardian's Name					Father/ Guardian's Name						
Address (if different from Patient's)					Address (if different from Patient's)						
City	ST		Zip			CityST		Zip			
Home Phone # Work Phone #					Home Phone # Work Phone #						
Cell Phone # Fax #					Cell Phone # Fax #						
S.S. # Email					S.S. # Email						
EmployerAddress					EmployerAddress						
CityZip					City ST Zip						
Primary Orthodont	tic Insuranc	e Inforn	nation		Secon	dary Ortho	odontic Insuran	ce Info	rmation		
Insurance Co. NamePhone #					Insurance Co. NamePhone #						
Insured's Name					Insured's Name						
Relationship to Patient					Relationship to Patient						
Insured's Birth Date S.S.#					Insured's Birth Date S.S.#						
Insured's Employer					Insured's Employer						
Person Responsible	for Accou	nt									
Name Relationship to			ship to Patient	Home Phone # Cell Phone #							
Billing Address			City	City		St	State		Zip		
S.S. #	E-mail					Employe	er	Wor	k Phone #		





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Medical History

Dental History

		2000001					
Please circle Yes or No if patient has	or has had	Please circle Yes or No					
[Y] [N] Joint swelling	[Y] [N] Tuberculosis	[Y] [N] Any injuries to face, mouth, teeth? (circle)					
[Y] [N] Bone disorders	[Y][N] Anemia	[Y] [N] Thumb, finger, lip sucking? (circle)					
[Y] [N] Heart trouble	[Y] [N] Epilepsy (convulsions)	[Y] [N] More than average amount of decay?					
[Y] [N] Mitral valve prolapse	[Y] [N] Prolonged bleeding	[Y] [N] Any missing permanent teeth?					
[Y] [N] Rheumatic trouble	[Y] [N] Faintness/Dizziness	[Y] [N] Any teeth removed by extraction?					
[Y] [N] Thyroid problems	[Y] [N] Tonsils removed	[Y] [N] Any difficulty in swallowing or chewing?					
[Y][N] Diabetes	[Y] [N] Adenoids removed	[Y] [N] Any pain or clicking on opening mouth?					
[Y] [N] Emotional problems	[Y] [N] Sore throats	[Y] [N] Is patient adopted? At what age?					
[Y] [N] Brain injury	[Y] [N] Tonsillitis	[Y] [N] Does patient visit the dentist regularly? Date of last visit					
[Y] [N] Kidney or liver involvement	[Y] [N] Earaches	[Y] [N] Has an orthodontist been consulted previously?					
[Y] [N] Joint prosthesis	[Y] [N] Arthritis	Reason:					
On items checked "Yes," please provide	us with a more detailed description:						
		Approximately how much has patient grown in the last year?					
Have you or any member of your family or Rheumatoid arthritis? [Y] [N] Lupu	close relative had: is?[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 trea (circle one) Very motivated Will co	tment: poperate 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.