Valley Orthodontics

Dr. Becky Maher
Healthy Smiles for a Lifetime!

Confidential Responsible Party Information

Responsible Party Name _____ Marital Status _____
Last First MI

Address _____ _____ ___ _____ # of Yrs._____ Own/Rent
Street City St. Zip

Previous Address _____ _____ ____ _____
(if less than 3 yrs.) Street City St. Zip

Home Phone_____ Cell Phone_____ Wk Phone_____ Relationship to Patient_____

E-mail_____ DOB:_____ SS#:_____

Employer _____ Occupation_____ # of Yrs._____

Spouse's Name_____Relationship to Patient_____
Last First MI

Employer _____ Occupation_____ # of Yrs._____

Cell Phone_____Wk Phone_____ DOB:_____SS#:_____

Confidential Patient Information

Name _____ M / F Birthdate_____
Last First MI

Address _____ _____ ___ _____
Street City St. Zip

Home Phone_____ E-mail _____SS#:_____

Who may we thank for referring you to our office _____

Dental Insurance Information

Primary Insurance Co._____ Phone #_____

Policy Holder's Name_____ID/SS#_____DOB:_____

Employer_____GR#_____ Union Local#_____

Secondary Insurance Co._____ Phone #_____

Policy Holder's Name_____ID/SS#_____DOB:_____

Employer_____GR#_____ Union Local#_____

over...

Emergency Information

Emergency contact name _____

Complete Address _____

Phone # _____ Relationship to Patient: _____

General and Medical History

General Dentist_____ Last Dental Visit_____ Other Family Treated @ VO_____

Physician_____ Last Visit_____ Phone # _____
Are you currently under the care of your physician? □ Yes □ No If Yes, explain_____

Are you pregnant? □ Yes □ No If so, how many weeks_____
Have your Tonsils or Adenoids been removed □ Yes □ No
Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? □ Yes □ No
Do you have any missing or extra permanent teeth? □ Yes □ No
Have you ever had an injury to: (select all that apply) □ Teeth □ Mouth □ Chin
Did you ever have any of the following habits? □ Lip sucking/biting □ Nail biting □ Mouth breather
□ Prolonged bottle/pacifier □ Clenching/Grinding teeth □ Tongue thrusting □ Thumb/finger Sucking
Do you have speech problems? □ Yes □ No If yes, explain_____
Do your gums bleed? □ Yes □ No Do you smoke? □ Yes □ No Do you like your smile? □ Yes □ No

Have you ever been evaluated for orthodontic treatment? _____
What are the main concerns that you would like to accomplish? _____

List all allergies or sensitivities_____

List all medications you are currently taking:	List any serious medical conditions treated for:
_____	_____
_____	_____
_____	_____
_____	_____

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical or dental status.
I hereby authorize the release of any information for the purpose of insurance processing and dental diagnosing by the doctor.
I understand that where appropriate, credit bureau reports will be obtained.

Signature _____ Date _____

This information has been updated by _____
Initial Date