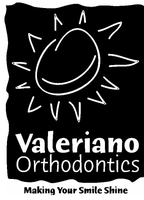

ADOLESCENT PATIENT INFORMATION

Patient's Name ____
First MI Last

Prefers to be called ___________________________________

Home Address ____

City_____________________ST__________Zip___________

Home # ( )__________________ Male ☐ Female ☐

Birth Date _______/_______/______ Age ___________

School ____

Interests, hobbies, sports __________________________

Siblings currently in our practice:

____

Patient's general dentist __________________________

Whom may we thank for referring you?

____

Have you ever seen an orthodontist? Yes ☐ No ☐

If so when? ______________ Whom? _____________

What are the main concerns that you would like orthodontics to accomplish?

____

RESPONSIBLE PARTY INFORMATION

Name ____
First MI Last

Address____

City _______________________ST______ Zip___________

How long at this address? ____________________________

Home # ( ) _____________ Cell # ( )____________

Work # ( )___________Martial Status ___________

SS # _______________________ DOB _____/_____/____

Relationship to Patient ___________________________

Employer ____

Occupation_____________________ # of years ________

SPOUSE'S INFORMATION

Spouse's Name ____________________________________
First MI Last

Spouse's Employer _________________________________

Occupation ______________ Work # ( )___________

SS#______________________DOB ______/_____/______

PERSON RESPONSIBLE FOR ACCOUNT

(If different from above)

Name ____
First MI Last

Billing Address ___________________________________

City _____________________ST_____ Zip ___________

Home # ( )____________ Work # ( )___________

Employer ____

SS# ____________________ DOB ______/______/_____

PRIMARY ORTHODONTIC INSURANCE

Insurance Co Name _______________________________

Address ____

City ___________________ST______ Zip ____________

Phone # ( )_______________ Group# _____________

Policy Holder's Name _____________________________

SS# ______________________ DOB _____/_____/_____

Employer ____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you

____

Address ____

City ____________________ST_______ Zip __________

Home # ( )_____________Work # ( )__________

Relationship to Patient ____________________________

7812 Fairview Road • Charlotte, NC 28226
Phone (704) 364-6544 • Fax (704) 364-8250 • www.valerianoorthodontics.com

MEDICAL HISTORY

Has the patient been under the care of a physician in the past 2 years? Explain the condition & duration.

Has your child had any of the following medical problems?

Y	N	Mental Disorders	Y	N	Fainting or Dizziness
Y	N	Venereal Disease	Y	N	Ever Taken Phen-Fen?
Y	N	Hepatitis	Y	N	Arthritis
Y	N	AIDS /HIV Positive	Y	N	Anemia
Y	N	Epilepsy	Y	N	Heart Trouble/Murmur
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Scarlet Fever
Y	N	Hemophilia	Y	N	Cancer
Y	N	High Blood Pressure	Y	N	Tuberculosis (TB)

IF PATIENT IS A MINOR

Y N Is child adopted?
Y N Are siblings adopted?
Y N Any learning disabilities?
Y N Has puberty begun?
Y N Has menstruation begun? (Girls)

List any other serious illnesses or operations not mentioned

____

List any drugs or medication currently taken

____

List any drug sensitivities or allergies including latex, metals or plastic ____

List other information you feel Dr. Valeriano should know

____

Please describe your child's current physical health

Good ☐ Fair ☐ Poor ☐

DENTAL HISTORY

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD) ? Y N

Does the jaw ever lock after opening? Y N

Have there ever been any injuries to the mouth/teeth?

____

Y	N	Clenching/Grinding	Y	N	Nursing/Bottle Habits
Y	N	Lip Sucking/Biting	Y	N	Speech Problems
Y	N	Mouth Breather	Y	N	Nail Biting
Y	N	Thumb/Finger Sucking	Y	N	Tongue Thrust

I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history on the above stated patient. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. In addition, I authorize Dr. Valeriano and his dental staff to perform a complete orthodontic evaluation.

____
Signature of parent or guardian Date

Our office is HIPAA compliant and the above signed has had the opportunity to review on behalf of the patient a copy of our office HIPAA policies.

OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials________________ Date _________________

Doctor's comments: ___________________________

____

____

____

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