Dr. Zach Casagrande / Dr. Kristin Nelson
Northern Virginia Orthodontics

patient information

Date _____ Email Address _____

Patient's name _____
Last First Middle Sex M/F

Address _____
Street City Zip

Birthdate _____ Social Security # _____

Home Phone _____ Work Phone _____ Cell Phone _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Patient's Dentist _____ Dentist Phone _____

Who suggested that you might need orthodontic treatment? _____

Main reason for seeking orthodontic treatment _____

responsible party information

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

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dental insurance information

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ ID _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ ID _____

Insurance Co. Address_____ Phone No. _____

emergency information

Name of nearest relative not living with you _____

Complete address _____

Street City Zip

Phone _____

fun facts for kids (and adults)

What would you like to see in your orthodontist? _____

Nickname_____ School and grade level _____

Favorite hobby_____ Favorite food _____

Favorite animal _____ Favorite person _____

Favorite sport_____ Favorite musical artist _____

Musical instruments played _____ Siblings? _____

Any other information you would like us to know: _____

_____

_____

_____

_____

_____

_____

_____

22855 Brambleton Plaza Suite 200 / Ashburn, VA 20148 / tel: 703.327.1718 / fax: 703.327.6718 / ashburnsmiles.com

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medical history

Physician _____ Date of Last Visit_____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details). Parents/Guardians please respond for minors.

Yes No Are you taking any medication/supplements/herbals? _____

Yes No Are you allergic to any medication/foods/latex/metals/acrylics/anesthetics etc? _____

Yes No Do you have a history of a major illness?_____

Yes No Have you had any major operations?_____

Yes No Have you ever been involved in a serious accident? _____

Yes No Are you/have you taking/taken bisphosphonates for osteoporosis or other bone diseases_____

Yes No Do you chew or smoke tobacco products? If so, how long? _____

Yes No Do you have or have you ever had a substance abuse problem _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Does your physician recommend premedicating with antibiotics prior to dental procedues?_____

dental history

Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

_____

Yes No Are you happy with the appearance of your teeth? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry?_____

Yes No Have you ever lost or chipped any teeth? _____

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Yes No Have there been any injuries to face, mouth or teeth?_____

Yes No Is any part of your mouth sensitive to temperature or pressure?_____

Yes No Do your gums bleed when you brush?_____

Yes No Are you concerned about bad breath?_____

Yes No Do you have any type of thumb or tongue habit?_____

Yes No Are you a mouth breather?_____

Yes No Do you have/have you had a tonsil or adenoid conditions?_____

Yes No Have you been told you have a tongue thrust? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping?_____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth?_____

Yes No Do you have “tension” headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____
If the patient is under age 16, height of parents? Mom_____ Dad_____

Yes No Are there any familial medical conditions we should know about? _____

Female Patients only:

Yes No Are you pregnant? _____

Yes No Has menstruation started (This is useful in monitoring/modifying growth of head and jaw bones)? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the medical or dental history, I will so inform this practice

Signature: _____

Date: _____

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