Dr. Zach Casagrande | Dr. Elvi Barcoma | Dr. Danielle Robb | Dr. Jessica Itani
Dr. Sharon Wang | Dr. Sonny Song | Dr. Kianoush Tari
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 _____

Patient's Dentist _____ Dentist Phone _____

Who suggested that you might need orthodontic treatment? _____

Main reason for seeking orthodontic treatment _____

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

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: _____

_____

_____

_____

_____

_____

_____

_____

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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	Herpes	Prolonged Bleeding
Anemia	Dizziness	High Blood Pressure	Radiation / Chemotherapy
Arthritis	Epilepsy	HIV / AIDS	Rheumatic Fever
Asthma or Hayfever	Gastrointestinal Disorders	Kidney problems	Sleep Apnea
Bone Disorders	Heart Problems / Heart Murmur	Nervous Disorders	Tuberculosis
Congenital Heart Defect	Hepatitis / Liver problems	Pneumonia	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 snore loudly? _____

Yes No Do you often feel tired, fatigued, or sleepy throughout the day? _____

Yes No Are you being treated for sleep apnea? _____

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: _____