IVERSON ORTHODONTICS

A PERFECT FIT FOR YOUR TEETH

**5401B Lee Highway – Arlington, VA – 22207**
**703-536-7846 info@iversonortho.com**

# WELCOME!

We want to welcome you to our orthodontic practice. We are looking forward to an enjoyable partnership which will result in healthier teeth and a sensational smile. Before we begin, we ask that you fill out this form in ink as completely as you can. Please print. Thank you.

## Patient Information - Adult

Full Name____________________________________________ I prefer to be called__________________________

Marital Status (Please circle one) Single Married Separated Divorced Widowed

Address ______________________________________________________________________________________

Age________ Date of Birth___________________ Gender M / F Social Security #_____________________________

Home Phone________________________ Work Phone_________________________ Cell Phone____________________

Referred to our office by______________________________________________________________________________

## Financially Responsible Party Information

Full Name____________________________________________ Relationship to Patient__________________

Address_____________________________________________________________ # Years at address __________

Home Phone__________________________ Work Phone_______________Cell Phone___________________________

Email_______________________________ Social Security #__________________________Birthdate______________

Employer______________________________ Occupation________________________ No. Years Employed__________

Other Responsible Party_____________________________________________Relationship to Patient_______________

Address_____________________________________________________________ # Years at address __________

Home Phone__________________________ Work Phone_______________Cell Phone___________________________

Email_______________________________ Social Security #__________________________Birthdate______________

Employer______________________________ Occupation________________________ No. Years Employed__________

## Dental Insurance Information

Policy Holder's Name_____________________________________ Employer_____________________________

Insurance Company________________________________ Group No_____________ Policy Number_________________

Insurance Co. Address___________________________________________ Insurance Co. Phone__________________

Policy Holder's Date of Birth______________________________________ S.S.N._______________________________

**Do you have dual coverage?** ____Yes ____No If yes, please complete the below information.

Policy Holder's Name_____________________________________ Employer_____________________________

Insurance Company________________________________ Group No_____________ Policy Number_________________

Insurance Co. Address___________________________________________ Insurance Co. Phone__________________

Policy Holder's Date of Birth______________________________________ S.S.N._______________________________

## Emergency Contact Information

Name of nearest relative not living with you_________________________________________________________

Complete Address____________________________________________________________________________

Phone__________________________________ Relationship____________________________________

## Patient Medical History

Physician's Name_________________________________________________ Office Phone________________________________

How would you describe your current health? ___Excellent ___Good ___Fair ___Poor

Are you currently under a doctor's care? ___Yes ___No If yes, for what?__________________________________

Are you currently taking any medications? ___Yes ___No If yes, please list_________________________________

Do you have any allergies to medications or latex? ___Yes ___No If yes, please list_________________________________

Are you taking bone density medications? ___Yes ___No

Do you have a history of any of the following? Please check all that apply.

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Hearing Problems
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous/Anxious
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Thyroid Disease
- ☐ Tuberculosis

Please list any other medical conditions not addressed above. ____________________________________________________

__________________________________________________________________________________________________________

## Patient Dental History

Dentist's Name__________________________________________________________ Date of last visit_________________________

Have you ever had an unfavorable experience with previous dental care? ___Yes ___No

Have you been evaluated for or had orthodontic treatment before? ___Yes ___No

If you answered yes to the above, please explain______________________________________________________________________

What are the primary concerns and final objectives expected from orthodontic treatment? ___________________________________

__________________________________________________________________________________________________________

Do you have a history of any of the following? Please check all that apply and give details below.

- ☐ Injuries to face, mouth or teeth
- ☐ Pain or tenderness in jaw
- ☐ Missing or extra permanent teeth
- ☐ Speech problems
- ☐ Tonsils removed
- ☐ Play musical instruments by mouth
- ☐ Thumb/Finger sucking
- ☐ Tongue Thrust
- ☐ Mouth breathing
- ☐ Nail/Lip Biting
- ☐ Clenching/Grinding Teeth

Details: __________________________________________________________________________________________________

__________________________________________________________________________________________________________

## Authorization and Release

Please Initial And Sign

_____ In accordance with HIPAA regulations, I understand that this information will be held in strict confidence. I hereby give my permission for the office of Iverson Orthodontics to use patient records for diagnosis, treatment, promotion, and education.

_____I authorize Dr. Iverson to release any information necessary for insurance purposes and authorize direct payment of insurance benefits to Dr. Iverson for services rendered.

Signature ________________________________________________________________ Date____________________