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 and your child 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 - Child

Patient's Full Name_____ Prefers to be called_____
Address_____ _____
Age_____ Date of Birth_____ Gender Gender School_____ Grade_____
Hobbies/Interests_____
Referred to our office by_____

Parent / Responsible Party Information

Full Name_____ Relationship to Patient_____
Marital Status (Please circle one) ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Address_____ # Years at address _____
Home Phone_____ Work Phone_____Cell Phone_____
Email_____ Social Security #_____Birthdate_____
Employer_____ Occupation_____ No. Years Employed_____
Other Parent/Guardian_____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_____

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 patient's current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is patient currently under a doctor's care? ☐ Yes ☐ No If yes, for what?_____

Is patient currently taking any medications? ☐ Yes ☐ No If yes, please list_____

Does patient have any allergies to medications or latex? ☐ Yes ☐ No If yes, please list_____

Has puberty begun? ☐ Yes ☐ No

Does patient have a history of any of the following? Please check all that apply.

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

Please list any other medical conditions not addressed above. _____

_____

Patient Dental History

Dentist's Name_____ Date of last visit_____

Has patient ever had an unfavorable experience with previous dental care? ☐ Yes ☐ No

Has patient 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? _____

_____

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

☐ Injuries to face, mouth or teeth	☐ Tonsils removed	☐ Tongue Thrust
☐ Pain or tenderness in jaw	☐ Plays a musical instrument by mouth	☐ Mouth breathing
☐ Missing or extra permanent teeth	☐ Thumb/Finger sucking	☐ Nail/Lip Biting
☐ Speech problems		☐ 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 of Parent/Guardian_____ Date_____