



**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 association 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 M / F _____	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 _____
Employer _____	Occupation _____
No. Years Employed _____	
Email _____	Social Security # _____
Birthdate _____	
Home Phone _____	Work Phone _____
Cell Phone _____	

Dental Insurance Information

Policy Holder's Name _____	Employer _____
Insurance Company _____	Group No. _____
Union Local No. _____	
Insurance Co. Address _____	Insurance Co. Phone _____
Do you have dual coverage?	No <input type="checkbox"/> Yes <input type="checkbox"/>
If yes:	
Policy Holder's Name _____	and Employer _____
Insurance Company _____	Group No. _____
Union Local No. _____	
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.

<input type="checkbox"/> Allergies	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nervous/Anxious
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> 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.

<input type="checkbox"/> Injuries to face, mouth or teeth	<input type="checkbox"/> Tonsils removed	<input type="checkbox"/> Tongue Thrust
<input type="checkbox"/> Pain or tenderness in jaw	<input type="checkbox"/> Plays a musical instrument by mouth	<input type="checkbox"/> Mouth breathing
<input type="checkbox"/> Missing or extra permanent teeth	<input type="checkbox"/> Thumb/Finger sucking	<input type="checkbox"/> Nail/Lip Biting
<input type="checkbox"/> Speech problems		<input type="checkbox"/> 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 _____