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PATIENT INFORMATION (CONFIDENTIAL)

Date: _____ Name: _____
First M. Last

Preferred Name to Be Called: _____ Date of Birth: _____ Age: _____

Sex Listed on Birth Certificate: Male Female Decline to Answer

Gender You Identify as: Male Female Transgender MtF Female Transgender FtM Male

Other, Please Specify:_____ Decline to Answer

Preferred Pronouns: He/Him She/Her They/Them

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Carrier:_____

Work Phone: _____ Email Address: _____

(For students) School: _____ Grade: _____

(For children) Sports and/or Hobbies: _____

Whom may we thank for referring you to us? _____

What concerns do you have regarding you or your child's teeth that you would like Dr. Valley to evaluate?

_____

Type "X" next to any of the following that you may have reservations about regarding orthodontic treatment:

Appearance Cost Pain Time

(For children) Names and ages of brothers and sisters:

_____

Have any members of your family been patients in our office? Yes No

Name(s): _____

Primary Responsible Party:

Name: _____

Relation to patient: _____

Date of birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Carrier:_____

Home Address: _____

_____

Email Address: _____

Secondary Responsible Party:

Name: _____

Relation to patient: _____

Date of birth: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Carrier:_____

Home Address: _____

_____

Email Address: _____

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Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Person financially responsible for this account: _____

Emergency Contact Person (Name/Relationship/Phone): _____

MEDICAL INFORMATION

Physician: _____ Date of Last Visit: _____

Address: _____ Office Phone: _____

Now or in the past, has the patient had?

Yes	**No**	AIDS or HIV positive?
Yes	**No**	Anemia?
Yes	**No**	Arthritis?
Yes	**No**	Asthma?
Yes	**No**	Birth defects or hereditary conditions?
Yes	**No**	Behavioral, Emotional or Learning conditions?
Yes	**No**	Bleeding disorders?
Yes	**No**	Bone disorders?
Yes	**No**	Bone fractures?
Yes	**No**	Cancer or tumors?
Yes	**No**	Diabetes?
Yes	**No**	Dizziness?
Yes	**No**	Eating disorders?
Yes	**No**	Endocrine disorders?
Yes	**No**	Epilepsy?
Yes	**No**	Fainting spells?
Yes	**No**	Gastrointestinal disorders?
Yes	**No**	Headaches?
Yes	**No**	Hepatitis?
Yes	**No**	Herpes?
Yes	**No**	Heart trouble?
Yes	**No**	High blood pressure?
Yes	**No**	Immune disorders?
Yes	**No**	Kidney disorders?
Yes	**No**	Liver disorders?
Yes	**No**	Muscle disorders?
Yes	**No**	Nervous disorders?
Yes	**No**	Rheumatic Fever?
Yes	**No**	Tonsil or Adenoid conditions?
Yes	**No**	Tuberculosis?

Allergies or reactions to any of the following:

Yes	**No**	Ibuprofen
Yes	**No**	Latex (e.g., gloves)
Yes	**No**	Vinyl
Yes	**No**	Acrylic
Yes	**No**	Metals (jewelry snaps)?
Yes	**No**	Foods or flavorings?

Specify: _____

Other: _____

Medications:

Yes **No** Is the patient taking medication, nutrient supplements, herbal medications or nonprescription medicine? Please name them and what they are taken for:

_____

_____

Does your physician require you to take any premedication before dental appointments?

Yes **No** Please describe: _____

Are there any major illnesses or medical conditions not mentioned above that we should be aware of?

_____

Women and Girls:

Yes **No** Has the patient started her monthly periods? Approximately when? _____

Yes **No** Is the patient pregnant?

DENTAL INFORMATION

Dentist: _____ Office Phone: _____

Address: _____

Date of last visit: _____ Frequency of visits: _____

How many times a day does the patient brush their teeth? _____ Floss their teeth? _____

Now or in the past, has the patient had?

Yes **No** Prior orthodontic examination or treatment? When? _____

Yes **No** Started teething very early or late?

Yes **No** Teeth sensitive to hot or cold?

Yes **No** History of speech problems? Been under the care of a speech therapist?

Yes **No** Mouth breathing habit?

Yes **No** Snoring or difficulty breathing?

Yes **No** Abnormal swallowing habit (tongue thrusting)?

Yes **No** Thumb, finger or lip sucking habit? Until what age? ____

Yes **No** Nail biting habit?

Yes **No** Frequent canker sores or cold sores?

Yes **No** Gums bleed when brushed or flossed?

Yes **No** Wisdom teeth extracted?

Yes **No** Extra or missing teeth from birth?

Yes **No** Periodontal "gum problems"?

Yes **No** Been under the care of a dental specialist? (Past or present)

Specialist: _____

Yes **No** Taking any forms of fluoride?

Yes **No** Any serious trouble associated with previous dental treatment?

Yes **No** Any relative with similar tooth or jaw relationships?

Yes **No** Sensitive or self-conscious about teeth?

Are there any dental conditions not mentioned above that you feel we should be aware of?

_____

ORTHODONTIC INSURANCE INFORMATION

Yes **No** Does the patient have Orthodontic Coverage?

Yes **No** Does the patient have Dental Coverage?

Primary Orthodontic Coverage

Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: _____

Group # (Plan, Local or Policy #):_____

Insured's Name: _____ Insured's Birth date: _____

Relation to Patient: _____

Insured's SS#: _____ Patient's SS#: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Orthodontic Coverage

Insurance Company's Name: _____

Insurance Company's Address: _____

Insurance Company's Phone #: _____

Group # (Plan, Local or Policy #):_____

Insured's Name: _____ Insured's Birth date: _____

Relation to Patient: _____

Insured's SS#: _____ Patient's SS#: _____

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Insured's Employer: _____

Employer's Address: _____

SIGNATURE(S) and DATE(S)

I/We certify that the information on this form is true and correct to the best of my/our knowledge, that it will be held in the strictest of confidence, and I/we will notify you of any changes.

Name: _____

Signature: _____ Date: _____

Name: _____

Signature: _____ Date: _____

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TEMPOROMANDIBULAR JOINT (TMJ) SCREENING FORM

Patient Name: _____ Birth date: _____ Age: _____

Please indicate "YES" or "NO" below whether or not the patient now experiences or has experienced the following:

Yes	No	Generalized jaw pain
Yes	No	Painful opening or closing of jaw
Yes	No	Joint noises upon opening or closing
Yes	No	Joint popping upon opening or closing
Yes	No	Difficulty or limitation in opening or movement of jaw
Yes	No	Irregular jaw movement when opening or closing jaw
Yes	No	Jaw "sticking", "locking", or dislocation
Yes	No	Stiff, tight or tired jaws
Yes	No	Facial pain (around ears, temples, and/or cheeks)
Yes	No	Facial or jaw pain or soreness when chewing
Yes	No	Recent or past injury of head, neck or jaw(s)
Yes	No	Headaches
Yes	No	Ear pain, ringing of the ear, or stuffiness
Yes	No	Difficulty swallowing
Yes	No	Neck aches
Yes	No	Tooth pain of unknown origin
Yes	No	Recent or evolving changes in bite
Yes	No	Continued tooth or jaw pain following dental treatment
Yes	No	Tooth clenching or grinding
Yes	No	Wear, have worn, or have been recommended a night guard for clenching or grinding
Yes	No	Current or past history of arthritic joints
Yes	No	Past history of treatment for TMJ issues

_____ _____ _____

Responsible Party Printed Name | Responsible Party Signature | Date

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SUPPLEMENTAL **INFORMED CONSENT**

Orthodontic Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal regulations and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or favorite restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, orthodontist, orthodontic staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

☐ Yes ☐ No

_____

Patient Name

_____ _____

Parent/Guardian Name *(if applicable)* Relation

_____ _____

Patient/Parent/Guardian Signature Date

American Association of Orthodontists®

CLEAR FORM