



FREDERICKSBURG ORTHODONTICS

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Date _____

PATIENT INFORMATION

Patient's Full Name _____ Nickname _____
Date of Birth _____ Gender _____ School _____
Address _____
City/State _____ Zip Code _____
Home Phone _____

RESPONSIBLE PARTY INFORMATION (for patient under the age of 18)

Father's Full Name _____
Mailing Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Email _____

Please Circle Parents are: Married Separated Divorced Widowed Never Married

Mother's Full Name _____
Mailing Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____ Social Security Number _____ Email _____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? YES NO If yes, please complete the following:

Insured's Name _____ Date of Birth _____ Insured's Social Security # _____
Insurance Company _____ Policy # _____ Group # _____
Insurance Phone # _____ Employer _____

Do you have dual coverage? YES NO If yes, please completes the following:

Insured's Name _____ Date of Birth _____ Insured's Social Security # _____
Insurance Company _____ Policy # _____ Group # _____
Insurance Phone # _____ Employer _____

Have any family members been treated at our office? _____

REFERRAL INFORMATION

How were you referred to us? Advertisement _____ Dentist _____
Patient _____ Physician _____ Other _____

CONTINUED ON BACK →

DENTAL HISTORY

Dentist Name: _____

Does patient receive regular dental checkups? YES NO Last Dental Exam: _____

Last Dental X-rays: _____

Cooperation with dentist: Excellent Good Fair Poor

Do you require pre-medication for dental visits: YES NO If yes, what ailment? _____

Has an orthodontist been consulted previously? YES NO

Have any teeth been injured or loosened by a fall or blow? _____

How often does patient brush their teeth? _____ Is floss used? _____ How often? _____

Brushing skills are: Excellent Good Fair Poor

The following are some habits commonly found which may influence tooth position. List info as pertains to patient:
Please indicate the age stopped (if stopped).

Y	N	Thumb sucking _____	Y	N	Snoring _____
Y	N	Tongue Thrust _____	Y	N	Grinding Teeth _____
Y	N	Lip Biting _____	Y	N	Nail Biting _____
Y	N	Mouth Breathing while asleep _____	Y	N	Pen Chewing _____

Does anyone else in the family have a similar dental condition? _____

HEALTH HISTORY

Physician Name: _____ Last visit to Physician: _____

Are any of the following conditions present or in past history?

Y	N	Allergies	Y	N	Rheumatic Fever
Y	N	Heart Ailment	Y	N	High or Low Thyroid
Y	N	Heart Murmur	Y	N	Dizziness
Y	N	Diabetes	Y	N	Fainting
Y	N	Tonsillitis	Y	N	Hepatitis
Y	N	Cold Sores or Blisters	Y	N	High or Low Blood Pressure
Y	N	Asthma	Y	N	Injuries to Face, Mouth or Teeth

Other: _____

Present General Health: Excellent Good Fair Poor

For young ladies, has your menstrual cycle begun? YES NO If yes, what age? _____

Are you currently under a physicians or specialist care? YES NO If yes, what for? _____

Are there any behavior or developmental issues we should be aware of: _____

Do you take any medications? YES NO If yes, medication and reason: _____

Have you ever taken Fosamax, Aetonel or any other medication of this type? _____

Do you have any allergies to medication? _____

Do you have any artificial cardiac valves or have had infective endocarditis, congenital heart disease or cardiac transplant? _____

Have you had any joint replacements? YES NO If yes, what: _____

Any medical alerts we should know about? (medications, latex) _____

Describe the reason for your child's visit today: _____

What is the nature of the problem as you see or understand it? Cosmetic Prevention Function

Are there any problems we may encounter of any sort prohibiting successful treatment? _____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further change to the information I have provide.

Signed: _____ Date: _____