VALDERRAMA ORTHODONTICS

321-425-5050

NEW PATIENT INFORMATION FORM

(This form is required to be completed prior to your exam…Thank you)

PATIENT INFORMATION

Today's Date_____

Patient's name (Last)_____, (First)_____, (MI)_____

Birthdate_____ Sex (check one) Male ○ Female ○ Social Security #_____

Address (Street)_____, (City)_____, (Zip)_____, (State)_____

Cell Phone _____ Email _____

Has the Patient or Family Member been to our office before? Yes ○ No ○ Who?_____

Dentist_____ Address_____

Has the Patient seen another Orthodontist Yes ○ No ○ Who?_____

How did you hear about Valderrama Orthodontics

☐Friend ☐Family ☐School Banner ☐School Ad ☐Social Media ☐Google

☐Dentist ☐Insurance ☐TV ☐Drive By ☐Email ☐_____

IF PATIENT IS A MINOR

Full name of the Parent/Legal Guardian (Last)_____, (First)_____, (MI)_____

Relationship to the Patient_____

Address (Street)_____, (City)_____, (Zip)_____, (State)_____

Is Patient covered by Insurance? Yes ○ No ○ Insurance Company/Plan_____

RESPONSIBLE PARTY INFORMATION

Name (Last)_____, (First)_____, (MI)_____

Address (Street)_____, (City)_____, (Zip)_____, (State)_____

Cell Phone _____ Email _____

Employer_____ Occupation_____ Work Number_____

Social Security Number _____

Permission is given to call person at work if required? Yes ○ No ○ Initial _____

MEDICAL/DENTAL HISTORY

Family Physician_____ Date of Last Physical _____ Date of last Dental Visit_____

Is Patient under a physician's care? Yes◯ No◯ If yes, for what reason_____

List all medications currently being taken_____

List any allergies to medications_____

Has Patient been diagnosed or treated for any of the following? (check all that apply)

☐Rheumatic Fever	☐Heart Disease	☐Lung Disorders	☐Bone Disorders
☐Corona Virus	☐Abnormal Blood Pressure	☐Tuberculosis	☐Arthritis
☐Hepatitis	☐Blood Disorders	☐Asthma	☐Anxiety
☐Aids/HIV Pos.	☐Heart Murmur	☐Seizures	☐Diabetes
☐Other _____			

Check all that apply:

1. Does the patient require medication before a dental appointment?☐
2. Is the patient allergic to Latex?☐
3. Does the patient have a persistent thumb or finger habit?☐
4. Is the patient a mouth breather?☐
5. Does the patient vomit, gag, or faint easily?☐
6. Does the patient experience headaches or neck aches?☐
7. Does the patient grind or clench their teeth?☐
8. Has the patient had any injuries involving the jaw or teeth?☐
9. Has the patient experienced popping or locking of the jaw?☐
10. Has the patient ever been evaluated for a jaw problem?☐
11. Has the patient been treated for periodontal disease or has treatment been recommended?☐
12. Does the patient/parent recognize that appointments will infringe on work/school?☐
13. Please provide any additional information you believe we should be aware of _____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient/Guardian Signature _____ **Date** _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient/Guardian Signature _____ **Date** _____