Kray ORTHODONTICS
2505 A Evelyn Byrd Ave.
Harrisonburg, VA 22801
P: 540.433.8814 | F: 540.433.7110
A healthy smile is a life-long smile.

Patient Information

Name		Nickname
Address		
City	State	Zip
Date of Birth	Male o Female o	Age
Cell Phone	Home Phone	
Email		
Family members treated at Kray Orthodonitcs		
How did you hear about our practice?		
What school do you attend?		
Whom may we thank for referring you to our office?		

Responsible Party

Responsible Party #1 Name		Marital Status
Relationship to patient	Cell Phone	
Home Phone	Email	
Address		
City	State	Zip
Date of Birth	SSN # - -	
Employer	Position	# Years Employed
Responsible Party #2 Name		Marital Status
Relationship to patient	Cell Phone	
Home Phone	Email	
Address		
City	State	Zip
Date of Birth	SSN # - -	
Employer	Position	# Years Employed

Dental Insurance Does your insurance cover orthodontic treatment? Yes o No o

Policy Holder's Name		Employer
Address		
City	State	Zip
Date of Birth	SSN# or ID#	
Insurance Co.		Group #
Insurance Co. Address		
City	State	Zip

I certify that I (or my dependent) have insurance coverage and assign directly to Kray Orthodontics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of the signature located on the back of this form on all insurance submissions.

Patient Dental History

Dentist Name	Date of Last Dental Visit

Check-up Frequency Per Year 1 o 2 o Less than once per year o

Has the patient had previous orthodontic treatment? Yes o No o

What is your main orthodontic concern?

Please select YES for any conditions the patient currently has or had had previously.

	Yes	No		Yes	No		Yes	No
Speech proplems/therapy?	o	o	Discomfort from teeth or gums?	o	o	Freqent sore throats?	o	o
Grind or clench teeth	o	o	Requires premeidcation?	o	o	Flouride treatments?	o	o
Oral Habits (thumb sucking, lip/nail biting)?	o	o	Pain, tenderness or noise in jaw?	o	o	Snores during sleep?	o	o
Injury to face, jaw, teeth or mouth	o	o	Frequent headaches?	o	o	Mouth breathing?	o	o
Any missing or extra permanent teeth?	o	o	Neck/shoulder pain?	o	o			

If any of the above questions were marked YES, please explain

Patients Under 18 Skip this section if it does not apply

Has the patient begun puberty? Yes o No o

If female, has menstruation begun? Yes o No o If male, has their voice changed or have facial hair? Yes o No o

In the past year, has the patient grown or changed shoe size? Yes o No o

Patient's interest in treatment? Interested o Not Interested o Indifferent o

Has either biological parent ever had orthodontic treatment? Yes o No o

Patient Medical History

Your current physical health is: Good o Fair o Poor o	Are you pregnant? Yes o No o
Physician Name	Last Physical

List any medication currently being taken by the patient.

List any drug allergies or sensitivities that the patient may have.

Please select YES for any conditions the patient currently has or had had previously.

	Yes	No		Yes	No		Yes	No
Ever Been Hospitalized	o	o	Family History Cancer	o	o	Kidney Disease	o	o
ADD/ADHD/Touretts	o	o	Growth Problems	o	o	Latex/Metal Allergy	o	o
Anemia	o	o	Handicaps/Disabilities	o	o	Nervous Disorders	o	o
Arthritis	o	o	Heart Attack/Stroke	o	o	Pneumonia	o	o
Asthma	o	o	Heart Disease	o	o	Prolonged Bleeding/Transfusion	o	o
Bone Disorders/Bone Loss	o	o	Heart Mumur	o	o	Received Radiation Treatment	o	o
Cancer	o	o	Hemophilla	o	o	Seizures/Epilepsy	o	o
Congential Heart Defect	o	o	Hepatitis	o	o	Smoker/ Use Tobacco Products	o	o
Diabetes	o	o	HIV/AIDS	o	o	Tonsils/Adenoids Removed	o	o
Eating Disorder	o	o	Hormone Therapy	o	o	Treated for Emotional Problems	o	o
Endocrine Problems	o	o	Hypertension/High Blood Pressure	o	o	Tuberculosis/Lung Disease	o	o

If any of the above questions were marked YES, please explain

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

Signature Date