DRS. RILEY, WILTSHIRE & BRASSINGTON
ORTHODONTISTS

Specialists in Orthodontics
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American Association of Orthodontists

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8503 Patterson Avenue
Richmond, VA 23229
804-740-7281

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1230 Alverser Drive
Midlothian, VA 23113
804-794-9557

Glen Allen
4204-A Park Place Court
Innsbrook Corporate Center
Glen Allen, VA 23060
804-747-9105

PATIENT REGISTRATION

Name_____ Nickname: _____ Sex _____ Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Previous orthodontic treatment? ☐ Yes ☐ No When?_____ How Long?_____ By Whom?_____

Reason for seeking orthodontic treatment _____

How did you hear about our office? _____

Name(s) of any other family member(s) who have sought treatment in our office_____

Family Dentist's Full Name _____ Last Dental Checkup _____

PATIENTS UNDER 18 YEARS OLD

Hobbies/Interests_____ School _____ Grade _____

Father's Full Name _____ SS# _____ Home Phone _____

Home Address (if different) _____

Employer _____ Occupation _____ Work Phone _____

Mother's Full Name _____ SS# _____ Home Phone _____

Home Address (if different) _____

Employer _____ Occupation _____ Work Phone _____

ADULT PATIENTS

Employer _____ Work Phone _____

Occupation _____ SS#_____ Home Phone_____

DATE: _____ **SIGNATURE**_____ **RELATIONSHIP TO PATIENT** _____

PLEASE COMPLETE THE MEDICAL HISTORY ON REVERSE SIDE

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MEDICAL HISTORY

Physician _____

Date of Last Physical _____

1. Present Health ☐ Good ☐ Fair ☐ Poor

2. Does patient have history of any of the following:

☐ Yes ☐ No Hyperactivity ☐ Yes ☐ No Hepatitis

☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No Asthma

☐ Yes ☐ No Heart Trouble ☐ Yes ☐ No Diabetes

☐ Yes ☐ No HIV Positive ☐ Yes ☐ No Epilepsy

☐ Yes ☐ No Emotional Problems

Explain _____

_____

3. ☐ Yes ☐ No Is patient on any regular medications now?

4. ☐ Yes ☐ No Are tonsils and adenoids present?

When Removed _____

5. ☐ Yes ☐ No Any allergies or drug sensitivies?

Explain _____

6. ☐ Yes ☐ No Digestive, swallowing or eating problems?

Explain _____

DENTAL HISTORY

1. Does patient have history of any of the following:

☐ Yes ☐ No Habit of sucking finger, thumb, lip, or other (circle one) How severe _____

How long _____ When _____ (night only, etc.)

☐ Yes ☐ No Endodontic (root canal) treatment

☐ Yes ☐ No Other orthodontic problems in family?

Treated _____ Untreated _____

☐ Yes ☐ No Clicking jaw when eating, yawning or at other times?

☐ Yes ☐ No Any history of TMJ or jaw joint pain?

Explain _____

☐ Yes ☐ No Do you feel the patient would cooperate fully in Orthodontic treatment?