



Welcome to our office! In an effort to provide the best service possible, please complete this form.

Your cooperation is appreciated

Patient Information - ADULT

Patient name: _____ **Nickname:** _____ **DOB:** ___/___/___
Sex: _____ **Age:** _____ **Home Address:** _____ **City:** _____
How long ___m ___y **Home Phone#:** _____ **Cell Phone#:** _____
E-Mail Address: _____
Employer: _____ **How Long:** _____ **Wk#:** _____ **S.S.#** _____
Marital Status S M D W
Has any one in your family had orthodontic treatment with Dr. Bayer or Dr. Curtis: _____
Spouse's Name: _____ **Employer:** _____ **Work#** _____
With employer ___m ___y **S.S.#** _____ **Cell Phone#:** _____
Whom may we thank for referring you? _____

Dental Insurance Information (PLEASE COMPLETE ALL INFORMATION)

Person who carries Primary Insurance: _____ **Social Security#:** _____
Date of Birth ___/___/___ **Address** _____
Employer _____ **Group #** _____ **ID on card** _____
Insurance Co. Name _____ **Phone #** _____

Person who carries Secondary Insurance: _____ **Social Security#:** _____
Date of Birth ___/___/___ **Address** _____
Employer _____ **Group#** _____ **ID on card** _____
Insurance Co. Name _____ **Phone #** _____

Person Financially Responsible for the Account

Name: _____ **Social Security #:** _____ **Relationship to Patient:** _____
Address _____ **How Long** _____
Home Phone # _____ **Work Phone #** _____ **Cell Phone #** _____
Employer _____ **How long:** _____

I understand a credit bureau report may be obtained.

Signature _____ **Date** _____

MEDICAL HISTORY

PATIENT NAME: _____

Physician: _____

Please circle YES or NO (If Yes, please fill in details)

YES NO Are you taking any medication? _____
YES NO Are you allergic to any medication? _____
YES NO Do you have a history of a major illness? _____
YES NO Have you had any major operations? _____
YES NO Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia Problems	Diabetes	Hepatitis/Liver problems	Pneumonia	Mental Health
Anemia	Dizziness	Herpes	Prolonged Bleeding	Neurological Issues
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy	Rheumatic Fever
Asthma or Hay fever	Gastrointestinal Disorders		HIV/Aids	Tuberculosis
Bone Disorders	Heart Problems		Kidney Problems	Tumor or Cancer
Congenital Heart Defect	Heart Murmur		Nervous Disorders	

Medical conditions not listed above: _____

DENTAL HISTORY

Dentist: _____ Date of last cleaning _____

Circle YES or NO regarding your present dental concerns:

YES NO Are you presently in any dental pain? _____
YES NO Have you experienced any unfavorable reaction to dentistry? _____
YES NO Have you lost or chipped any permanent teeth? _____
YES NO Have there been any injuries to face, mouth, or teeth? _____
YES NO Is any part of your mouth sensitive to temperature or pressure? _____
YES NO Do your gums bleed when you brush? _____
YES NO Do you have any type of thumb or tongue habit? _____
YES NO Are you a mouth breather? _____
YES NO Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
YES NO Do your teeth or jaws feel uncomfortable when you awake in the morning? _____
YES NO Are you aware of your jaw clicking or popping? _____
YES NO Are you aware of clenching your teeth during the day? _____
YES NO Have you ever been told that you grind your teeth? _____
YES NO Do you have "tension headaches"? _____
YES NO Have you experienced chronic ringing in your ears? _____
YES NO If the patient is under age 16, height of parents? Mom _____ Dad _____
YES NO Are you aware that some appointments will be during school/work hours?

Female Patients:

YES NO Are you pregnant?

Benefits of Orthodontics: Aesthetics, Health and Functions. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical and/or dental history.

I authorize Dr. Peter F. Bayer and Dr. Leigh B. Curtis to perform a complete orthodontic evaluation.

Signature _____

Date _____