



We welcome you and your child to our office! In an effort to provide the best service, please complete this form. Your cooperation is appreciated

PATIENT INFORMATION - CHILD

Patient name: _____ **Nickname:** _____ **DOB:** _____
Age: _____ **Sex:** _____ **School:** _____ **Grade** _____
Home Address: _____ **City:** _____
Home Phone#: _____ **Patient Cell Phone#:** _____ **Patient E-Mail Address:** _____
 If patient is a minor is he/she adopted? _____ **Whom may we thank for referring you?** _____

Family Information

Siblings names with birthdates: _____
Has any one in your family had orthodontic treatment with Dr. Bayer or Dr. Curtis: _____
Parent marital status: Single Married Separated Divorced Widowed

Mother's Name: _____ **Social Security** _____ **Date of Birth:** _____
Mother's Address: _____
How long: _____ **Home Phone#:** _____ **Work Phone#:** _____ **Cell Phone#:** _____
Mother's E-Mail: _____ **Employer:** _____ **How long:** _____

Father's Name: _____ **Social Security** _____ **Date of Birth:** _____
Father's Address: _____
How long: _____ **Home Phone#:** _____ **Work Phone#:** _____ **Cell Phone#:** _____
Father's E-Mail _____ **Employer:** _____ **How long:** _____

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: _____ **Rent** ___ **or Own** ___ **How Long** _____
Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____
Employer: _____ **Date of Birth:** _____

I understand, 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? _____
YES NO Are you currently taking Fosamax or Fosamax Plus D? _____

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

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia	Mental Health Problems
Gastrointestinal Disorders	Dizziness	Herpes	Prolonged Bleeding	Neurological Issues
Anemia	Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	HIV/AIDS	Rheumatic Fever	Bone Disorders	Heart Problems
Kidney Problems	Tuberculosis	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 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, whom 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 under 18 Only:

YES NO Are you pregnant? _____

YES NO Has menstruation started? _____ Date: _____

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.

Parent Signature _____
Parent Signature _____

Date _____
Date _____