WELCOME

TO BAILEY ORTHODONTICS

PATIENT INFORMATION

Today's Date ____________________ [ ] Male [ ] Female

Name: ____

Nickname: ______________________ DOB: ___/___/______

School: ______________________________ Grade: _______

College Student: [ ]Full-time [ ]Part-time [ ]N/A

Home Phone #: ______________________________________

Address: ____

City: _______________________ State: _____ Zip: ________

Patient is: [ ]Adult [ ]Child, and resides with:

[ ]Mother [ ]Father [ ]Other: ____________________

General Dentist: _________________Last Visit: __________

Frequency of dental visits: ____________________________

Whom may we thank for referring you?_________________

IF PATIENT IS A CHILD, PARENT/GUARDIAN INFORMATION

Marital Status: [ ]Single [ ]Married [ ]Separated

[ ]Divorced [ ]Widowed

Mother's Name: ____________________________________

DOB: ___/___/______ SSN: ___________________________

Employer: ____

Work #: ____________________ Cell #: ________________

Home #, if different than child: _____________________

Address: ____

City: __________________ State: ________ Zip: _________

Email address: ______________________________________

Father's Name: _____________________________________

DOB: ___/___/______ SSN: ___________________________

Employer: ____

Work #: ____________________ Cell #: ________________

Home #, if different than child: _____________________

Address: ____

City: __________________ State: ________ Zip: _________

Email address: ______________________________________

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PARENT/GUARDIAN/SELF

Name: ____

Billing Address: _____________________________________

City: __________________ State: _______ Zip: __________

Home #: _________________ Relation: _________________

Employer: ____

Work #: ___________________ SSN: ___________________

Email: ____

PRIMARY DENTAL/ORTHODONTIC INSURANCE

Orthodontic Coverage? [ ]YES [ ]NO [ ]UNSURE

Insurance Company Name: _____________________________

Insurance Company Address: ___________________________

City: ___________________State: _______ Zip: __________

Insurance Company Phone #: ___________________________

Policy Holder: ______________________________________

Relationship to Patient: _______________________________

Group #: _________________ Policy #: _________________

Policy Holder DOB: ___/___/______ SSN: ______________

Policy Holder's Employer: _____________________________

SECONDARY DENTAL/ORTHODONTIC INSURANCE

Orthodontic Coverage? [ ]YES [ ]NO [ ]UNSURE

Insurance Company Name: _____________________________

Insurance Company Address: ___________________________

City: ___________________State: _______ Zip: __________

Insurance Company Phone #: ___________________________

Policy Holder: ______________________________________

Relationship to Patient: _______________________________

Group #: _________________ Policy #: _________________

Policy Holder DOB: ___/___/______ SSN: ______________

Policy Holder's Employer: _____________________________

PATIENT'S CURRENT HEALTH:

PHYSICAL: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

EMOTIONAL: [ ]Excellent [ ]Good [ ]Fair [ ]Poor

KNOWN OR SUSPECTED ALLERGIES:

[ ]Antibiotics:___________________________________

[ ]Other Medications:______________________________

[ ]Foods: ______________________________________

[ ]Environmental allergies: _________________________

[ ]Plastics [ ]Latex [ ]Metals: _____________________

[ ]NONE PLEASE INITIAL: __________

CURRENT MEDICATIONS:

[ ]Heart Medications [ ]Diet aids [ ]Vitamins [ ]Insulin

[ ]Birth Control Pills [ ]Muscle Relaxants

[ ]Antibiotics: ___________________________________

[ ]Pain Medication: ______________________________

[ ]Other: _______________________________________

[ ]NONE PLEASE INITIAL: __________

If the patient is a child, has puberty begun? [ ]Yes [ ]No

For girls, has menstruation begun? [ ]Yes [ ]No

Patient's Primary Care Physician: ____________________

Phone #: __________________ Last Visit: ___________

DOES/DID THE PATIENT HAVE ANY OF THE FOLLOWING HABITS?

[ ]Clenching/Grinding Teeth [ ]Nursing Bottle Habits

[ ]Lip Sucking/Biting [ ]Speech Problems

[ ]Mouth Breather [ ]Thumb/Finger Sucking

[ ]Nail Biting [ ]Tongue Thrust

[ ]Regularly snores

[ ]Sleep disturbance:_______________________________

PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

[ ]Desires treatment [ ]Only if necessary [ ]Uncooperative

[ ]Unwilling but will cooperate if treatment is indicated

ORTHODONTIC EXAM PROMPTED BY:

[ ]Dentist [ ]Doctor [ ]Parent [ ]Spouse [ ]Sibling

[ ]Friend [ ]Self [ ]Other:____________________

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

[ ]AIDS / HIV+ [ ]Asthma [ ]Autoimmune Disorders

[ ]Blood disease/Abnormal Bleeding [ ]Bone Disorders

[ ]High/Low Blood Pressure [ ]Diabetes [ ]Dizziness

[ ]Eating Disorders [ ]Endocrine Problems [ ]Hepatitis

[ ]Emotional Disorders [ ]Heart Disease [ ]Tuberculosis

[ ]Congenital Heart Defect [ ]Heart Murmers

[ ]Handicaps/Disabilities [ ]Kidney Disease [ ]Cancer

[ ]Rheumatic/Scarlet Fever [ ]Convulsions/Epilepsy

[ ]Ringing in the ears [ ]Liver Problems

[ ]Frequent sore throat / tonsillitis

[ ]Major Surgeries: _______________________________

[ ]Hospital Admissions: ___________________________

Comments: ____________________________________

____

CHIEF ORTHODONTIC CONCERNS:

____

____

Please check all that apply:

[ ]Crowding [ ]Overbite [ ]"Buck Teeth"

[ ]Receded Jaw [ ]Prominent Jaw [ ]Gummy Smile

[ ]Neck Pain [ ]Space between teeth [ ]Stuffy/Ringing Ears

[ ]Pain or Difficulty chewing [ ]Headache/Face Pain

[ ]Gum disease/recession [ ]Jaw dysfunction [ ]Jaw Pain

[ ]Mouth too small [ ]Clicking Jaw Joint [ ]Irregular Teeth

[ ]Protrusion of Teeth [ ]Irregular Facial Appearance

[ ]Other: ______________________________________

FAMILY MEMBERS WITH SIMILAR CONDITIONS:

[ ]Father [ ]Mother [ ]Sibling [ ]Other: ___________

Has the patient ever been evaluated for or had orthodontic treatment before? [ ]No [ ]Yes: ____________________

Have there been injuries to the face, mouth, teeth, or chin?

[ ]No [ ]Yes _________________________________

Any musical instruments played: ____________________

Adenoids/Tonsils removed? [ ]Yes [ ]No

Any known missing or extra permanent teeth? [ ]Yes [ ]No

Tenderness/Pain in jaw joint (TMJ / TMD)? [ ]Yes [ ]No

Brush teeth daily? [ ]Yes [ ]No Floss Daily? [ ]Yes [ ]No

MEDICAL, DENTAL, OR SURGICAL INFORMATION
NOT COVERED ELSEWHERE ON THIS FORM?

PLEASE DESCRIBE: ____

____

____

____

PLEASE LIST A RELATIVE OR FRIEND NOT LIVING WITH YOU

Name: ____________________ Relation: __________ Phone #: ____________

Address: ____

STREET ADDRESS CITY STATE ZIP

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

Signature: ____________________ Date: ____________

I hereby authorize Bailey Orthodontics to release all necessary information to secure payment of benefits and I assign directly to the doctor all insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submission. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature of patient or parent/guardian: ____________________ Date: ____________

The parent or guardian who accompanies the child is responsible for payment. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.