MICHAEL R. BAILEY D.M.D. ORTHODONTICS

WELCOME TO OUR OFFICE

Tiut	Nickname: Patient's Name: Address: Town: Home Phone: Cell Phone:	Zip: Date of Birth:		PARENT OR NEIGHBOR (ALTERNATE CONTACT PERSON) NAME:			
the second se			mployer:				
	Person Responsible for Account:						
	Billing Address:						
	Town:		Zip:				
	Billing Phone:	Cell .Phone:	E	Email:			
	SSN:	DOB:					
Patient's Dentist:	Referred By:		Patient's	Physician:			
Has an orthodontist been	consulted before? No Yes	S Orthodo	ontist's Name:				
CHIEF CONCERN (In your own words, what problems have you noticed with your teeth or bite?):							

MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF

YES

NO

1) HEART TROUBLE/MURMUR 16) FREQUENT HEADACHE

U 11) SINUS DISORDER

16) EPILEPSY

D21) RESPIRATORY DISORDERS

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2) HIGH BLOOD PRESSURE	DIZZINESS/FAINTING	12) ALLERGIES, HIVES	3 17) STOMACH DISORDERS	I 22) ASTHMA
3) RHEUMATIC FEVER	1 8) THYROID DISORDER	LI 13) DIABETES	1 1B) ANEMIA	LI 23) PSYCHOLOGICAL DISORDER
14) STROKE	9 KIDNEY DISORDER	U 14) ARTHRITIS	J 19) CANCER	24) TONSILIADEN OID PROBLEM
3 5) BLEEDING DISORDER	.1 10) LIVER DISORDER	T 15) TUBERCULOSIS(TB)	2 20) HEPATITIS	25) SPEECH DISORDER

26) HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE LAST 2 YEARS? 27) HAVE YOU HAO ANY SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION? 28) ARE YOU TAKING ANY DRUGS OR MEDICATIONS? 29) (FEMALE ONLY) ARE YOU PREGNANT?

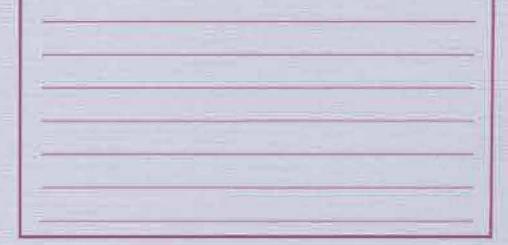
DENTAL HISTORY

1.8.1

30) HAVE YOU HAD ANY TRAUMATIC INJURIES TO THE FACE. MOUTH OR TEETH? 31) HAS ANY OTHER MEMBER OF THE FAMILY HAD ORTHODONTIC TREATMENT? 32) DOES ANY MEMBER OF THE FAMILY HAVE A SIMILAR ARRANGEMENT OF THE TEETH?

33) DO YOU HAVE A HISTORY OF THUMB OR FINGER SUCKING?
34) DO YOU HAVE A HISTORY OF LIP OR CHEEK BITING?
35) DO YOU HAVE A HISTORY OF CHRONIC MOUTH BREATHING?
36) DO YOU HAVE A HISTORY OF GRINDING O RCLENCHING THETEETH?

DO YOU HAVE ANY RELATIVES OR CLOSE FRIENDS WHO ARE PATIENTS IN OUR PRACTICE?



Please elaborate on any checked items: NUMBER

Ortho. Insurance Co.:

Primary Ins. Co. name:	Subscriber's name:	Date of birth:
Subscriber's ID# or SS#:	Group #	
Secondary Ins. Co. name:	Subscriber's name:	Date of birth:
Subscriber's ID# or SS#:	Group #	

As a courtesy to our patients, we will submit any necessary insurance claims provided that we have been informed of the current insurance coverage and have all necessary information needed to process the claim. The patient will be responsible for any uncovered insurance portion.

I (patient) authorize release of any necessary information for submission of any insurance claim.

x Patient's signature

Date

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Michael R. Balley, D.M.D.

Date

Sometimes records (xrays, study models or diagnostic photographs) are necessary to complete the examination. If so, we will inform you prior to taking of any records and we will also give you an estimated cost.

I hereby authorize Michael R. Bailey, D.M.D. to perform an orthodontic examination and take the necessary records.

x Patient's signature

Date