MICHAEL R. BAILEY D.M.D.
ORTHODONTICS

WELCOME TO OUR OFFICE

Nickname: _____ Sex: ☐M ☐F

Patient's Name: _____

Address: _____

Town: _____ Zip: _____

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Email: _____

PARENT OR NEIGHBOR
(ALTERNATE CONTACT PERSON)

NAME: _____

PHONE: _____

Patient's Employer: _____ Patient's Marital Status Spouse's Name: _____

Business Phone: _____ S M W D Employer: _____

☐ ☐ ☐ ☐ Business Phone: _____

Cell Phone: _____

Person Responsible for Account: _____

Billing Address: _____

Town: _____ Zip: _____

Billing Phone: _____ Cell Phone: _____ Email: _____

SSN: _____ DOB: _____

Patient's Dentist: _____ Referred By: _____ Patient's Physician: _____

Has an orthodontist been consulted before? ☐ No ☐ Yes Orthodontist'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:

☐ 1) HEART TROUBLE/MURMUR
☐ 2) HIGH BLOOD PRESSURE
☐ 3) RHEUMATIC FEVER
☐ 4) STROKE
☐ 5) BLEEDING DISORDER
☐ 6) FREQUENT HEADACHE
☐ 7) DIZZINESS/FAINTING
☐ 8) THYROID DISORDER
☐ 9) KIDNEY DISORDER
☐ 10) LIVER DISORDER
☐ 11) SINUS DISORDER
☐ 12) ALLERGIES/HIVES
☐ 13) DIABETES
☐ 14) ARTHRITIS
☐ 15) TUBERCULOSIS(TB)
☐ 16) EPILEPSY
☐ 17) STOMACH DISORDERS
☐ 18) ANEMIA
☐ 19) CANCER
☐ 20) HEPATITIS
☐ 21) RESPIRATORY DISORDERS
☐ 22) ASTHMA
☐ 23) PSYCHOLOGICAL DISORDER
☐ 24) TONSIL/ADEN OID PROBLEM
☐ 25) SPEECH DISORDER

YES	NO	
☐	☐	26) HAVE YOU BEEN UNDER A PHYSICIAN'S CARE IN THE LAST 2 YEARS?
☐	☐	27) HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION?
☐	☐	28) ARE YOU TAKING ANY DRUGS OR MEDICATIONS?
☐	☐	29) (FEMALE ONLY) ARE YOU PREGNANT?

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

DENTAL HISTORY

☐	☐	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 OR CLENCHING THE TEETH?

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. Bailey, D.M.D.

_____

x

Signature (employee/subscriber) **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**