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: _____

School: _____ Grade: _____

Child's Cell Phone: _____

GRANDPARENT OR NEIGHBOR
(ALTERNATE CONTACT PERSON)

NAME: _____

PHONE: _____

Father's Name: _____

Employer: _____

Business Phone: _____

Cell Phone: _____ Email: _____

Person Responsible for Account: _____

Billing Address: _____

Town: _____ Zip: _____

Billing Phone: _____ SSN: _____

Parent's Marital Status

S M W D

☐ ☐ ☐ ☐

Mother's Name: _____

Employer: _____

Business Phone: _____

Cell Phone: _____ Email: _____

Person Responsible for Account: _____

Billing Address: _____

Town: _____ Zip: _____

Billing Phone: _____ SSN: _____

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

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

Please Describe the patient's problem in your own words. _____

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) HAS THE PATIENT BEEN UNDER A PHYSICIAN'S CARE IN THE LAST 2 YEARS?
☐	☐	27) HAS THE PATIENT HAD ANY SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION?
☐	☐	28) IS THE PATIENT TAKING ANY DRUGS OR MEDICATIONS?
☐	☐	29) (FEMALE ONLY) IS THE PATIENT PREGNANT?

DENTAL HISTORY

☐	☐	30) HAS THE PATIENT 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) DOES THE PATIENT HAVE A HISTORY OF THUMB OR FINGER SUCKING?
☐	☐	34) DOES THE PATIENT HAVE A HISTORY OF LIP OR CHEEK BITING?
☐	☐	35) DOES THE PATIENT HAVE A HISTORY OF CHRONIC MOUTH BREATHING?
☐	☐	36) DOES THE PATIENT HAVE A HISTORY OF GRINDING OR CLENCHING THE TEETH?

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

Not that we know of.

GROWTH HISTORY

☐	☐	37) Does any member of the family have a significant underbite or prominent lower jaw?
☐	☐	38) (female only) Has the patient started her monthly period? When? _____
		39) Is the patient maturing ☐ early ☐ average ☐ late?
		40) What is the height of the patient? _____
		What is the height of the patient's father? _____
		What is the height of the patient's mother? _____

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/parent/guardian will be responsible for any uncovered insurance portion.

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

_____

x
Signature (parent/guardian) **relationship** **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
Signature (parent/guardian) **relationship** **Date**