BATES ORTHODONTICS

Patient Information

Today's Date_____ ☐Male ☐ Female

Name _____
Last First MI

Address _____

City_____ State_____ Zip_____

Preferred Phone _____ ☐Cell ☐Home ☐Work

Alternate Phone _____ ☐Cell ☐Home ☐Work

Nickname _____

Date of Birth_____ Age _____

Patient's E-mail_____

School _____

Patient's Hobbies/Interests _____

_____

Medical/Dental History

General Dentist _____

Last Dental Visit _____

Is the patient under the care of a physician for a specific problem at this time? _____

Physician's Name _____

Are you taking any prescription medication? ☐Yes ☐No

If so, which ones? _____

Are you currently taking a bisphosphonate for osteoporosis?☐Yes ☐No

☐Fosamax ☐Boniva ☐Actonel ☐Other_____

List any drug sensitivities _____

Adolescent patients only

Is the patient adopted? ☐Yes ☐No

Has the patient reached puberty? ☐Yes ☐No

Girls: Has she started menstruation? ☐Yes ☐No

If yes, month/year _____

Boys: Has his voice changed? ☐Yes ☐No

Please check all the following that apply

Asthma	☐	Jaw Joint Pain	☐	AIDS/HIV	☐
Diabetes	☐	Bone Disorders	☐	Heart Condition	☐
Epilepsy	☐	Teeth Grinding	☐	Kidney Problems	☐
Hepatitis	☐	ADD/ADHD	☐	Endocrine Problems	☐

Have you been informed of a nickel/latex allergy? ☐Yes ☐No

Have you been informed of any missing/extra teeth? ☐Yes ☐No

Has an orthodontist previously been consulted? ☐Yes ☐No

Have you had any previous orthodontic treatment? ☐Yes ☐No

Responsible Party Information

Name _____

Relationship to Patient_____

Employer _____

Occupation _____

Work # _____

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Responsible Party's E-mail

_____

Address _____

City_____ State_____ Zip _____

Spouse/Other _____

Relationship to Patient_____

Employer _____

Occupation _____

Work # _____

Are there any other children that you would like us to evaluate?

☐Yes ☐ No _____

Family members previously treated here _____

_____

How did you decide to come to our office?

_____

Insurance

Primary Dental Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name _____

Relationship to Patient _____

Employer _____

Insurance Company _____

Date of Birth _____ ID/SS# _____

Insurance Phone # _____

Secondary Dental Insurance

Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name _____

Relationship to Patient _____

Employer _____

Insurance Company _____

Date of Birth _____ ID/SS# _____

Insurance Phone # _____

X

Signature of Parent/Patient/Guardian **Date**