bauer orthodontics

Confidential Patient Information

Date ______________

Patient name ______________________________ Sex **M** **F**

Address ______________________________

Home phone ______________ Cell ______________ Birth date ______________

If patient is a minor, give names of parents or guardians ______________

Whom may we thank for referring you to our office ______________

Responsible Party Information

Name ______________________________ Marital Status ______________

Residence ______________________________

Mailing address ______________________________

How long at this address ______________ Email address ______________

Cell #______________ Home#______________ Work#______________

Previous address (if less than 3yrs) ______________________________

Social security #______________ Birth date ______________ Relationship to patient ______________

Employer ______________ Occupation ______________Years employed ______________

Spouse's name ______________ Relationship to patient ______________

Employer ______________ Occupation ______________ Years employed ______________

Social security #______________ Birth date ______________ Cell # ______________

Dental Insurance Information

Insured name ______________ Insured SS # ______________

Insurance company______________ Group # ______________ Local #______________

Insurance company address ______________________________

Insured employer ______________________________

Do you have dual coverage **yes** **no** If yes list additional information below.

Insured name ______________ Insured SS # ______________

Insurance company ______________ Group # ______________ Local #______________

Insurance company address ______________________________

Insured employer ______________________________

Emergency Information

Name of nearest relative not living with you ______________________________

Complete address ______________________________

Phone #______________ Cell #______________ Work #______________

(continued on other side)

Medical History

Patient physician ____

Is patient taking any medications at present **yes** or **no** If yes, please list ____________________

____

Allergic to any medicines ____

Have you had allergies or reactions to any of the following? Circle yes, no, or don't know.

yes no dk … latex (gloves, balloons)
yes no dk … metals (jewelry)
yes no dk … acrylics
yes no dk … foods
yes no dk… ibuprofen (Motrin, Advil)
yes no dk … other antibiotics

Does or did the patient ever have:

yes no dk … birth defects or hereditary problems
yes no dk … endocrine or thyroid problems
yes no dk … diabetes
yes no dk … kidney problems
yes no dk … cancer, tumor, radiation treatment or chemotherapy
yes no dk … stomach ulcer, hyperacidity, acid reflux
yes no dk … aids or HIV positive
yes no dk … hepatitis, jaundice or other liver problems
yes no dk … tuberculosis, polio, mononucleosis, pneumonia
yes no dk … seizures, fainting spells, neurologic problems
yes no dk … arthritis or osteoporosis
yes no dk … mental health disturbance/depression
yes no dk … high or low blood pressure
yes no dk … blood disorders/bleeding problems/Anemia
yes no dk … heart defects, heart murmur, rheumatic heart disease
yes no dk … angina, arteriosclerosis, stroke or heart attack
yes no dk … headaches or migranes
yes no dk … asthma, sinus problems, hayfever
yes no dk … tonsil/adenoid condition or removal

Dental History

Patient dentist ______________________ Date of last exam ____________________

Teeth extracted ____________ missing teeth ____________ thumb/finger habit ____________

Any injuries to teeth, face, head, neck or jaw__________ If so, please explain ____________________

____

Any tooth clenching or grinding at night ____________ Mouth breathing habit or snoring ____________

History of speech problems … **yes** **no** speech therapy … **yes** **no** tongue thrusting … **yes** **no**

Has an orthodontist been consulted previously ______________________________

Main concern in seeking orthodontic care ______________________________

Signature of patient, parent or guardian ______________________________

Signature of orthodontist ______________________________