Dr. Grant S. Bailey

1 Tell us About Your Child/Yourself

Today's Date: _____

Patient Name: _____
Last First Middle

Birthdate: ____/____/____ Age: Years: _____ Months: _____

Nickname: _____ ☐ Male ☐ Female

Patient's Home Address: _____

_____
City State Zip

School: _____ Grade: _____

Patient's Home #: _____ SS #: _____

2 General Information

Who is accompanying the patient today? _____

Name: _____

Do you have legal custody of this patient? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Relative or Friend (circle one) not living with you:

Name: _____ Phone: (____) _____

Address: _____

_____
City State Zip

3 Parent's Information

Parents Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ **Father** ☐ **Step Father** ☐ **Guardian** ☐ **Self**

Name: _____ Birthdate: ____/____/____

Address: (if different than Patient's) _____

_____
City State Zip

SS #: _____ Hm#: (____) _____

WK#: (____) _____ Ext: _____ Cell/Other#: (____) _____

Email: _____

Employer: _____

How long there: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for this Patient, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

Group# (Plan, Local, or Policy#): _____

☐ **Mother** ☐ **Step Mother** ☐ **Guardian** ☐ **Spouse**

Name: _____ Birthdate: ____/____/____

Address: (if different than Patient's) _____

_____
City State Zip

SS #: _____ Hm#: (____) _____

WK#: (____) _____ Ext: _____ Cell/Other#: (____) _____

Email: _____

Employer: _____

How long there: _____ Occupation: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for this Patient, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

Group# (Plan, Local, or Policy#): _____

4 Release

Signature (Parent's signature if minor) _____ Date ____/____/____

Confidential (for record and pretreatment evaluation). I understand that where appropriate, credit bureau reports may be obtained.

5

Dental and Medical History

Dentist:_____

Physician: _____

1. Date of last medical examination: _____
2. Is patient presently under physician's care? ☐ No ☐ Yes
3. Is patient presently receiving any medication? ☐ No ☐ Yes
4. Has patient ever had (Circle) Rheumatic fever, Diabetes, chronic kidney, heart, lung or liver problems, ☐ No ☐ Yes
   Epilepsy, Cerebral palsy, comas, Hepatitis or AIDS? ☐ No ☐ Yes
5. Has patient ever had an unusual reaction to any drug such as penicillin or local anesthetics? ☐ No ☐ Yes
6. Has the patient ever had abnormal bleeding problems? ☐ No ☐ Yes
7. Are there any other pertinent medical problems? ☐ No ☐ Yes
8. Date of last dental examination: _____
9. Has the patient had any teeth removed by a dentist? ☐ No ☐ Yes
10. Has the patient had any problems with sore or bleeding gums? ☐ No ☐ Yes
11. Does the patient brush his/her teeth in the:
    morning? _____ After Lunch? _____ Bedtime? _____
12. Has the patient ever received a severe blow on the teeth or jaws? ☐ No ☐ Yes
13. Did the patient ever suck his/her thumb? ☐ No ☐ Yes
14. Does the patient bite his/her fingernails? ☐ No ☐ Yes
15. Does the patient grind his/her teeth at night? ☐ No ☐ Yes
16. Does the patient breath through his/her mouth? ☐ No ☐ Yes
17. Is the patient concerned about the appearance of his/her teeth? ☐ No ☐ Yes
18. Has the patient ever been teased about the appearance of his/her teeth? ☐ No ☐ Yes
19. Has the patient ever had previous orthodontic consultation and/or treatment? ☐ No ☐ Yes
    By whom? _____
20. Has any member of the family had orthodontic treatment? ☐ No ☐ Yes
21. Has the patient ever had speech therapy? ☐ No ☐ Yes
22. Who noticed the need for orthodontic treatment?
    Dentist_____ Patient_____ Parent_____
23. Does the patient want his/her teeth straightened? ☐ No ☐ Yes
24. Are you aware that some appointments will infringe on school time? ☐ No ☐ Yes

6

Growth Information

Siblings Names:_____ Ages: _____

At what age did patient show the greatest increase in height? _____

Boys- Has patient shown signs of pubertal development? _____

Girls- Has the patient shown signs of pubertal development? _____

Has patient started her monthly period? _____ At what age _____