Baker Orthodontics

Patient Information Sheet

Name: _____ Nickname: _____ Email Address: _____

Patients Address: _____ Telephone: _____

DOB: Age: Sex: Height: Weight: Contact for Scheduling: _____

School/Employer: _____ Grade/Position: _____

Interest/Sports _____

Primary [] Mother [] Father [] Step Parent [] Self [] Other (specify) Email Address: _____

Responsible Party: _____ Telephone: _____

Address: _____ How Long? _____

Employer: _____ Telephone: _____

Secondary [] Mother [] Father [] Step Parent [] Self [] Other (specify) Email Address: _____

Responsible Party: _____ Telephone: _____

Address: _____ How Long? _____

Employer: _____ Telephone: _____

How Did You Hear About Us? [] Dentist [] Patient [] Relative [] Acquaintance [] Other _____

Whom May We Thank For Referring You To Us? _____ Present Dentist: _____

Reason For Consultation: _____ Date of last visit to dentist: _____

Physician Name & Number: _____

Circle Yes or No for which the patient has a history:

Aids/HIV+	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	Sleep Apnea	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Venereal Disease	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	TMJ Problems	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Tooth Grinding	Y N
Aspirin	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Tuberculosis	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N		
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca/Sjogren	Y N		
Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Speech problems	Y N		
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Snoring	Y N		

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Adolescent Females: Have you started Menstruating? (Used to determine growth stage) Y N At what age? _____

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Has an orthodontist been consulted previously? _____ Have you had previous orthodontic treatment? _____

Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____

Any other questions? _____

Names and Ages of Brothers & Sisters: _____

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ [] Mother [] Father [] Step Parent [] Self [] Other (specify) _____

Policy Holders Birthdate & ID #: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ [] Mother [] Father [] Step Parent [] Self [] Other (specify) _____

Policy Holders Birthdate & ID #: _____

I the undersigned have given the above dental and medical information, have reviewed it and find it accurate. If there are any later changes to the history records I will inform the practice. I also authorize Dr. David M. Baker to perform an orthodontic examination and to bill my insurance for the treatment rendered, if applicable.

Signature: _____ Relationship To Patient: _____ Date: _____