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.

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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? By whom? _____	❑ No	❑ Yes
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 _____

Bailey Orthodontics Social Media Release

Bailey Orthodontics utilizes Facebook®, Instagram®, Twitter®, YouTube®, Google® and other social media platforms for the free exchange of information and customer service as well as marketing. At times, we will take pictures of our various patients during their treatment or other interactions and potentially post them to the various social media outlets that we use, as well as to our website. We will not post a picture of your child or yourself without your consent, nor will we use any photos taken and used for confidential patient records.

I _____ give my consent to Bailey Orthodontics for myself or child to use pictures or video that include myself or child in their various social media campaigns. By signing, I understand that Bailey Orthodontics may still use pictures of myself or child even after treatment has concluded.

Signature_____ Date_____ Accept ❑ Decline ❑