PATIENT REGISTRATION

Date ______________

Once completed, please print to PDF and send to bairdorthodontics@emaildds.com

PATIENT INFORMATION

Last Name *First Name* *Middle Initial*

Address ______________________________

City ______________________________

State__________Zip ______________________

Preferred Phone______________________

Cellular provider ______________________

Occupation ___________________________

Email ________________________________

Dentist ______________________________

Sex: M F Birthday______________________

Whom may we thank for referring you? Please specify.

Dentist: ________________________

Google/Internet: __________________

Yelp: ___________________________

Friend: _________________________

Family: _________________________

Insurance Network: ________________

Instagram:_______________________

Other (please specify): _____________

____

Has anyone else in the family been treated/seen at Baird Orthodontics? ___________________________

PRIMARY INSURANCE INFORMATION

Is patient covered by dental insurance? If yes, please complete the following.

Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient__________Birthday ____________ Name of Employer ________________________

Insurance Company ______________________________ Contact # ____________________________

Group # ____________ Subscriber Soc. Sec. #_______________Subscriber #________________________

Delta/CA or Delta/State: ____________________________ Employer Phone ________________________

A dental insurance policy is a contract between the insured and the insurance company. Our professional services are rendered and charged directly to the patient's account and the patient or person responsible for the account is responsible for payment of all fees incurred. We will gladly assist you in submitting insurance claims pertaining to any charge for care in our office.

ADDITIONAL INSURANCE

Subscriber Last Name ***First Name*** ***Middle Initial***

Relation to Patient__________Birthday ____________ Name of Employer ________________________

Insurance Company ______________________________ Contact # ____________________________

Group # ____________ Subscriber Soc. Sec. #_______________Subscriber #________________________

Delta/CA or Delta/State: ____________________________ Employer Phone ________________________

DENTAL HISTORY & STATUS

When were you last seen by a dentist? ___________________________

Yes No Are you taking any pills or medications for dental reasons? If yes, please elaborate
____

Yes No Have there been any unusual reactions to dental medications? If yes, please elaborate
____

Yes No Have you had trouble associated with dental treatment? If yes, please elaborate
____

Yes No Have you seen a periodontist, endodontist, or oral surgeon? If yes, please elaborate
____

Yes No Have you had previous orthodontic treatment or consultation? If yes, when?
____

Yes No Has any member of your family had orthodontic treatment? If yes, please elaborate
____

Yes No Have you had any teeth extracted? If yes, why?
____

Yes No Have you ever injured or broken any teeth? If yes, please elaborate
____

Yes No Have you ever been injured in the head or face? If yes, please elaborate
____

Yes No Do you have any missing or extra teeth? If yes, please elaborate
____

Yes No Do you have any problem with eating, chewing, or swallowing? If yes, please elaborate
____

Yes No Do you have any dental or facial pain? If yes, please elaborate
____

Yes No Does your jaw joints make noise or hurt when opening, closing or chewing?

If yes, please elaborate ____

Yes No Do you habitually grind or clench teeth together?

Yes No Are you of any swellings or growths in the mouth or on the face?

If yes, please elaborate ____

Yes No Do you have any negative or resistant feelings about orthodontic treatment?

Yes No Are you especially concerned about orthodontic treatment?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Are you specifically resistant to braces?

Yes No Is there any other information we should know?

If yes, please elaborate ____

MEDICAL HISTORY

Who is the patient's physician?______________________________

When was the patient last seen by a physician? _________________________

Yes No Have you seen an ENT specialist, endocrinologist, neurologist, allergist, hematologist, cardiologist, psychiatrist, or plastic surgeon? If yes, please elaborate:

____ __________________

Yes No Is there a current medical problem? If yes, please elaborate

____

Yes No Are you taking any pills, medications, or drugs? If yes, please elaborate

____

Yes No Have you had an unusual reaction to any medication?

If yes, please elaborate ____

Yes No Have you had a serious illness? If yes, please elaborate? ________________________________

Yes No Have you had any surgery or been hospitalized?

If yes, please elaborate ____

Yes No Are there any congenital (that the patient was born with) problems? If yes, please elaborate

____

What is the patient allergic to? ____

Has the patient ever been diagnosed or treated for any of the following?

Yes No *Diabetes*	Yes No *Anemia*	Yes No *Liver problem*
Yes No *Thyroid problem*	Yes No *Jaundice*	Yes No *Tonsilitis*
Yes No *Sickle cell anemia*	Yes No *Cancer*	Yes No *Fainting*
Yes No *Heart trouble*	Yes No *Breathing trouble*	Yes No *Epilepsy*
Yes No *AIDS or HIV+*	Yes No *Rheumatic Fever*	Yes No *Tuberculosis*
Yes No *Emotional problems*	Yes No *Cerebral palsy*	Yes No *Kidney problem*
Yes No *Prolonged bleeding*	Yes No *Arthritis*	Yes No *Asthma*
Yes No *Bone disease*	Yes No *Hepatitis*	Yes No *Low blood pressure*
Yes No *Multiple sclerosis*	Yes No *Stomach ulcers*	

Reason for visit:

____

Patient Signature ____ Date __________________

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