ORTHODONTIC
NEW PATIENT FORM

Baker ORTHODONTICS

190 Curtis Pkwy NE A,
Calhoun, GA 30701
706.602.0540

Full Name _____ Preferred Name _____

Date of Birth _____ Age _____ Sex _____ Male _____ Female

Email_____ Home Phone # _____

Cell Phone # _____ Allow Text Alerts? _____ Yes _____ No

Mailing Street or Box # _____

City/State/Zip _____

Carrier _____ Name of Account Owner _____

Billing Street or Box # _____

City/State/Zip _____

Do you have orthodontic coverage on your dental insurance? _____ Yes _____ No

If so, Name of Company _____

Policy # _____ Group # _____

Patient's Dentist _____ Last visit to dentist _____

Name and age of children in the family _____

_____

_____

Which friend may we thank for referring you?

_____

Relationship?

❒ Former Patient ❒ Family ❒ Friend ❒ Dentist
❒ Yellow Pages ❒ Radio ❒ TV ❒ Newspaper

COMPLETE ONLY IF ABOVE IS A MINOR

Father's Name _____

Date of Birth _____

Driver's License # _____

Employer _____

Occupation _____

Employer's Address _____

_____

Mother's Name _____

Date of Birth _____

Driver's License # _____

Employer _____

Occupation _____

Employer's Address _____

_____

Parent's are:

❒ Married ❒ Divorced ❒ Separated ❒ Widowed

School _____ Grade _____

COMPLETE ONLY IF ABOVE IS AN ADULT

Date of Birth _____

Driver's License # _____

Employer _____

Occupation _____

Employer's Address _____

_____

How long? _____

Business Phone # _____

If married, Spouse's Name _____

Date of Birth _____

Driver's License # _____

Employer _____

Occupation _____

Employer's Address _____

_____

How long? _____

Business Phone # _____

MEDICAL HISTORY

Is the patient under the care of a physician for a specific problem at the present time? _____ Yes _____ No

Physician _____

List of current medications being taken

_____

_____

List any allergies or drug sensitivities

_____

_____

Is there a history of serious illness, accident or operation?

_____

_____

ICE contact _____ Phone # _____

PLEASE CHECK THE FOLLOWING AS THEY APPLY:

❒ AIDS
❒ Allergies / asthma
❒ Arthritis
❒ Bleeding problems
❒ Diabetes
❒ Ear infections
❒ Emotional problems
❒ Endocrine problems
❒ Epilepsy
❒ Galucoma
❒ Head or facial injury
❒ Hearing problems
❒ Hepatitis / liver disease
❒ High blood pressure
❒ Kidney problems
❒ Nerve problems
❒ Rheumatic fever
❒ Tonsilitis

DENTAL HISTORY

❒ Yes ❒ No Have there been any injuries to the face, mouth, or teeth? If so, please list and describe.

_____

_____

❒ Yes ❒ No Has patient ever sucked thumb or finger? Please list any additional details below.

_____

_____

❒ Yes ❒ No Have you been informed of any missing or extra permanent teeth?

_____

_____

❒ Yes ❒ No Has an orthodontist been consulted previously? Please list any additional details below.

_____

_____

❒ Yes ❒ No Has patient had any previous orthodontic treatment? If so, by whom?

_____

_____

Reason for seeking orthodontic care?

_____

Any additional information which you feel would make your orthodontic treatment journey with us more enjoyable?

_____