ROBERT R. MORTIMER D.M.D.
orthodontic specialist

Child Patient Information

Date ____________ 20 ______ Account Number ______________ (for office use only)

Patient's Name: ____ Extension ______ (Jr., I, II, etc.)
Last First M

Address: ____
City ____________________________ State __________ Zip __________
Home Phone _______________ Business Phone _______________ (mother or father) Cell Phone _______________ (mother or father)
E-Mail ________________________________
Patient's Birthdate _____________________________ Age _______ Gender-Female ____ Male ____

Dr. Mortimer Office: **Plum/Murrysville Penn Hills Munhall Elizabeth Twp.**
(Circle correct office)

Billing Party ______________________________ Address ______________________________
(who is financially responsible) (if different)

Do you have insurance that covers Orthodontic Treatment _____ Yes _____ No

Physician ____________________ Oral Surgeon __________________ Phone No. ______________
Father's Name ________________________________ single married divorced separated
Father's Social Security # ________________________
Employed by ____ D.O.B. ______________________
Occupation ____________________ Business Phone ______________________________________
Father's Dental Insurance ________________________________ Phone ______________________
Mother's Name __________________________________ single married divorced separated
Mother's Social Security # __________________________
Employed by ____ D.O.B. ______________________
Occupation ____________________ Business Phone __________
Mother's Dental Insurance ________________________________ Phone# ______________________
School ____ Grade ______________________
Referred by __________________ Family Dentist ________________ Phone No. ________________
Emergency Contact Person ________________________________ Phone No. ________________

If parent address is different from child, please complete: Name ___________________________
Address ____ Phone No. ________________

Names and ages of other children in the family ____

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Patient's Medical History

Is the patient in Good Health? ___ Yes ___ No

Height ____________ Weight ____________

Has the patient been treated for any of the following?

__ Diabetes	__ Tuberculosis	__ Endocrine problems
__ Pneumonia	__ Heart Trouble/Murmur	__ Anemia
__ Prolonged bleeding	__ Epilepsy	__ Fainting/Dizziness
__ Rheumatic Fever	__ Asthma	__ Nervous Disorders
__ Bone Disorders	__ Kidney/Liver	__ Frequent colds/sore throats/ear problems

Other: ____

Present Medications: ______________________ Allergy/Drug reactions __________

Does the patient ever take any anti-inflammatory drugs? ______________________

Have the tonsils or adenoids been removed? ___ yes ___ no Date: ______________

Does your child snore? ___ yes ___ no

Onset of Puberty ___ yes ___ no Date: ______________

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Dental History

Have there been any injuries to the face, mouth, or teeth? ___ yes ___ no

Date: ______________ Explain ______________________

Has the patient ever sucked a thumb, finger or pacifier? ___ yes ___ no Until what age? ______

Does the patient have any speech problems? ___ yes ___ no Explain ______________

Is the patient a mouth breather? ___ yes ___ no

Have you been informed of any missing or extra permanent teeth? ___ yes ___ no

Does the patient have any of the following symptoms?

_____ Head or Neck pain _____ Click, popping or grinding in the jaw joint

_____ Ear pain _____ Frequent Headaches _____ Jaw locking

Does the patient play sports? ______________ a musical instrument? ______________

Has an Orthodontist been consulted previously? ___ yes ___ no Date ______________

In your own words what do you see as the problem? ______________________

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Parent/Patient Signature