

Robert R. Mortimer, DMD
orthodontic specialist

Child Patient Information

Date _____ 20 _____ Account Number _____ (for office use only)

Name: _____ Extension _____ (Jr., I, II, etc.)
Last First M

Address: _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

E-Mail _____ (mother or father) _____ (mother or father)

Patient's Birthdate _____ Age _____ Gender- Female _____ Male _____

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

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

Do you have insurance that covers Orthodontic Treatment _____ YES _____ NO

Home Phone _____ Business Phone _____ Cell Phone _____
(mother or father) (mother or father)

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 _____

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 _____

Patient's Medical History

Is the patient in Good Health? yes no

Height _____ Weight _____

Has the patient been treated for any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Endocrine problems |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Trouble/Murmur | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Kidney/ Liver | <input type="checkbox"/> Frequent colds/sore throats/ ear prob. |

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 _____
Onset of Puberty yes no Date _____

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? _____

Parent/Patient Signature