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 ________________ Cell Phone: ____________

(mother or father) (mother or father)

Email: _________________________________

Patient's birthdate _______________ Age__________ Gender Female _____ Male _____

Referred by __________________________________ Family Dentist __________________

Primary Care Physician _______________________________

Parent/Guardian ____________________________________Mom/Stepmom/Dad/Stepdad/Guardian

Address _____________________________ City _____________________ PA ____________

Date of Birth ____________ Social Security # _______________ Cell Phone _________________

Parent/Guardian ____________________________________Mom/Stepmom/Dad/Stepdad/Guardian

Address _____________________________ City _____________________ PA ____________

Date of Birth ____________ Social Security # _______________ Cell Phone _________________

Parent/Guardian ____________________________________Mom/Stepmom/Dad/Stepdad/Guardian

Address _____________________________ City _____________________ PA ____________

Date of Birth ____________ Social Security # _______________ Cell Phone _________________

Parent/Guardian ____________________________________Mom/Stepmom/Dad/Stepdad/Guardian

Address _____________________________ City _____________________ PA ____________

Date of Birth ____________ Social Security # _______________ Cell Phone _________________

Emergency Contact Person ____________________________________Relationship _____________

Phone # _____________________

Primary Dental Insurance Carrier ______________________________Member ID _______________

Policy holders name _________________________________ Relationship ______________________

Date of Birth ________________________ Social Security # ________________________________

Secondary Dental Insurance Carrier ___________________________Member ID ________________

Policy holders name ________________________________ Relationship _______________________

Date of Birth _______________________ Social Security # ___________________________________

Name and ages of other children in the family ____

Is the patient in good health ? ____ Yes ____ No

Onset of puberty? __ Yes __ No Date _________________

Has the patient been treated for any of the following:

__ Diabetes
__Pneumonia
__ Prolonged Bleeding
__ Rheumatic Fever
__ Bone Disorders
__ Autism
__ Tuberculosis
__ Heart Trouble/Murmur
__ Epilepsy
__ Asthma
__ Kidney/Liver
__ Endocrine Problems
__ Anemia
__ Fainting/Dizziness
__ Nervous Disorders
__ Frequent colds/sore throat/ear problems

Other ______________________________ Allergy/Drug reactions __________________________

Does the patient regularly take any anti-inflammatory drugs? __ Yes __ No (Advil, Ibuprofen, Celebrex)

Have the tonsils or adenoids been removed? __ Yes __ No Date ________________________

Does your child snore? __ Yes __ No Is your child a mouth breather? __ Yes __ No

DENTAL HISTORY

Have there been any injuries to the face, mouth or teeth? __ Yes __ No
Date of injuries ________________ 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 ____________________________
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
___ Ear pain
__ Click, popping or grinding in the jaw joint
__ Frequent headaches
___ Jaw locking

Does the patient play sports? _________________ a musical instrument? _____________________
Has an Orthodontist been consulted previously? __ Yes __No Date _______ Who _____________

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

I consent to any and all diagnostic procedures and orthodontic treatment provided by Dr. Mortimer, assistants, or other personnel. I release any information concerning my (my child's) health care, advice and treatment to another dentist for evaluating and administering treatment. I authorize payment of any dental benefits to Dr. Mortimer for services rendered.

Signature ___________________________________ Relationship ________________ Date __________