Brian Fryar, D.D.S., M.S.D

Member American Association of Orthodontics

Patient Information

Date _____ Age _____ (Yrs.) _____ (Mos.) Birthdate _____

Patient's Name _____ (Last) _____ (First) _____ (Nickname) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone # _____

Hobbies _____ School _____ Grade _____

General Dentist _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

❑ Father ❑ Step-father ❑ Guardian

Name _____ (Last) _____ (First) _____ (Middle) Financially Responsible ❑ **Yes** ❑ **No**

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

❑ Mother ❑ Step-mother ❑ Guardian

Name _____ (Last) _____ (First) _____ (Middle) Financially Responsible ❑ **Yes** ❑ **No**

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Social Security # _____ Birthdate _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Insurance Information

Insured's Name _____ (Last) _____ (First) Relationship _____

Social Security # _____ ID # _____

Employer _____

Insurance Company _____

Birthdate _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Phone _____

Orthodontic Coverage ❑ Yes ❑ No

Additional Coverage

Insured's Name _____ (Last) _____ (First) Relationship _____

Social Security # _____ ID # _____

Employer _____

Insurance Company _____

Birthdate _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Phone _____

Orthodontic Coverage ❑ Yes ❑ No

Emergency Information

Name of Nearest Relative Not Living With You _____

Relationship to patient _____

Complete Address _____

Phone _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that where appropriate, credit bureau reports may be obtained.

Signature Of Patient Or Parent of Minor _____ Date _____

Brian C. Fryar, D.D.S., M.S.D.

Fryar Orthodontics

Member **American Association of Orthodontics**

Child Medical History

Patient's Name _____ Date _____

Is patient in good health? _____ Yes ❑ No ❑

Does patient have any history of major illness? _____ Yes ❑ No ❑

Has patient ever been under the care of a physician for illness? _____ Yes ❑ No ❑

Please list _____

_____

_____

Please explain any pertinent Medical History: _____

_____

_____

Check the following for which patient has been treated:

_____ Glaucoma	_____ Bone disorders	_____ Endochrine Problems
_____ Diabetes	_____ Tuberculosis	_____ Prolonged Bleeding
_____ Pneumonia	_____ Anemia	_____ Fainting or Dizziness
_____ Heart Trouble	_____ Epilepsy	_____ Nervous Disorders
_____ Rheumatic Fever	_____ Asthma	_____ Liver Involvement
_____ HIV Positive / Aids	_____ Kidney Involvement	

Does patient have a tendency to colds? _____ Sore throats? _____ Ear infections? _____

Have tonsils and adenoids been removed? _____ What age? _____

List any allergies or medication now being taken. Give reasons: _____

_____

_____

Has patient reached puberty? Girls: Has she started menstruation Yes ❑ No ❑

Boys: Has his voice changed Yes ❑ No ❑

Height _____ Weight _____ Does patient gag easily? Yes ❑ No ❑

Name and age of Brothers and Sisters: _____

_____

Patient's Dental History

Have there ever been any injuries to the face, mouth or teeth?	yes	no
Have you ever sucked your fingers or thumb? Until what age?	yes	no
Do you have any speech problems?	yes	no
Are you a mouth breather? While awake?	yes	no
While asleep?	yes	no
Have you been informed of any missing or extra permanent teeth?	yes	no
Have you consulted an orthodontist previously?	yes	no
Did either parent have orthodontic treatment?	yes	no

Do you have pain in the jaw joints? ❑ Right ❑ Left Do you have popping or cracking of the jaw joint? ❑ Right ❑ Left

When did this begin? _____