Buck Orthodontics
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1821 Austin Street
Klamath Falls, OR 97603
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PATIENT INFORMATION DATE:_____

Name: _____ _____ Male / Female
Last First Middle Nickname

DOB: _____ Age: _____ Height: _____ Weight: _____ SSN: _____

School: _____ Grade: _____ Hobbies/Sports: _____

Address: _____
Street City State Zip

Home Phone: _____ Alt/ Cell Phone: _____ Email: _____

Dentist: _____ Physician: _____ Father Height: _____ Mother Height: _____

Other family members seen in our office:_____

Who can we thank for referring you to our office:_____

RESPONSIBLE PARTY INFORMATION

Father's Name: _____

Address: _____

City:_____ Zip:_____

Number of Years at Current Address: _____

Phone (Home): _____ (Work): _____

(Cell): _____ Email: _____

DOB: _____ SSN: _____

Employer:_____

Occupation:_____ # Years:_____

Single Married Separated Divorced (circle one)

Spouses Name:_____

DOB: _____ Employer:_____

Occupation:_____ # Years:_____

Mother's Name: _____

Address: _____

City:_____ Zip:_____

Number of Years at Current Address: _____

Phone (Home): _____ (Work): _____

(Cell): _____ Email: _____

DOB: _____ SSN: _____

Employer:_____

Occupation:_____ # Years:_____

Single Married Separated Divorced (circle one)

Spouses Name:_____

DOB: _____ Employer:_____

Occupation:_____ # Years:_____

Patient Lives With (circle one): Mother Father Both Other _____

EMERGENCY CONTACT INORMATION

Name of nearest relative not living with you & relationship: _____Home Phone: _____

Alt/Cell Phone: _____ Address: _____

ORTHODONTIC INSURANCE INFORMATION

Subscriber Name: _____ ID#/SSN#:_____DOB:_____

Insurance Company: _____ Group #: _____ Phone:_____

Insurance Company Address: _____

Do you have Dual Coverage? Y / N

2nd Subscriber Name: _____ ID#/SSN#:_____ DOB:_____

Insurance Company: _____ Group #: _____ Phone:_____

Insurance Company Address: _____

MEDICAL & DENTAL HISTORY

How is the present health of the patient?_____

How is the present growth & development of the patient? _____

Has the patient been under a physician's care during the last 2 years? Y / N Is the patient taking any medication? Y/ N

If so, what medication? _____

List any allergies:_____

(Females only) Is the patient pregnant? Y / N Due date?_____

Has the patient ever had any of the following?

Y / N	Abnormal bleeding/ Hemophilia	Y / N	High Blood Pressure/Low Blood Pressure
Y / N	Adenoids/ Tonsils removed Age?_____	Y / N	HIV/AIDS
Y / N	Anemia	Y / N	Hospitalized
Y / N	Arthritis	Y / N	Immune Disorders
Y / N	Asthma/ Hay Fever	Y / N	Kidney Disease
Y / N	Bone Disorders	Y / N	Lung Disease
Y / N	Breathing Problems	Y / N	Major Injuries
Y / N	Cancer or Tumor	Y / N	Neck Pain
Y / N	Chest Pain	Y / N	Nervous Disorders
Y / N	Diabetes/Low Sugar	Y / N	Other serious illness
Y / N	Endocrine Disease	Y / N	Pneumonia
Y / N	Eating Disorder	Y / N	Radiation/Chemotherapy
Y / N	Epilepsy	Y / N	Rheumatic Fever
Y / N	Fainting/Dizziness	Y / N	Sinus Problems
Y / N	Gastrointestinal Disorders	Y / N	Skin Disorder
Y / N	Glaucoma	Y / N	Thyroid Disorders
Y / N	Headaches	Y / N	Tuberculosis
Y / N	Heart Defects/Disease/Murmur	Y / N	TMD / Jaw problems
Y / N	Hepatitis/Liver Disease	Y / N	Vision, Hearing, Speech Problems
Y / N	Herpes		
Y / N	Face, Head, Neck, or Teeth Injuries	Y / N	Early loss of any baby teeth
Y / N	Difficulty chewing	Y / N	Usually breathe through mouth
Y / N	Mouth ulcers/ sore gums	Y / N	Missing or extra permanent teeth
Y / N	Teeth sensitive to hot and/ or cold	Y / N	Play a wind instrument Type?_____
Y / N	Suck thumb or have other habits	Y / N	Endodontic work
Y / N	Grind teeth	Y / N	Periodontal work
Y / N	Bite fingernails	Y / N	Permanent teeth removed

Please explain any "YES" answers to the above questions? _____

_____

What are the names and ages of other children living at home? _____

_____

Have you had any previous orthodontic treatment in the family? _____

Date of last dental visit?_____ How often does the patient brush their teeth?_____ floss?_____

What concerns you most about the patient's teeth or facial appearance?_____

_____

I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical/dental or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment. I authorize payment of any insurance benefit to this office. I consent to the examination and understand that a credit bureau check may be obtained where necessary.

Parent/Guardian Signature:_____Relationship:_____Date:_____