Buck Orthodontics
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PATIENT INFORMATION DATE:_____

Name: _____ _____
Last First Middle Nickname

DOB: _____ Age: _____ Male / Female SSN: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Hobbies: _____

Employer: _____ Occupation: _____ # Years: _____

Dentist: _____ Physician: _____ Number of Years at Current Address: _____

Single Married Separated Divorced (circle one)

Spouses Name: _____ _____
Last First Middle Nickname

DOB: _____ Employer: _____ Occupation: _____ # Years:_____

Other family members seen in our office:_____

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

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? _____

MEDICAL & DENTAL HISTORY CONTINUED

Has the patient ever had any of the following?

Y / N Abnormal bleeding/ Hemophilia
Y / N Adenoids/ Tonsils removed Age?_____
Y / N Anemia
Y / N Arthritis
Y / N Asthma/ Hay Fever
Y / N Bone Disorders
Y / N Breathing Problems
Y / N Cancer or Tumor
Y / N Chest Pain
Y / N Diabetes/Low Sugar
Y / N Endocrine Disease
Y / N Eating Disorder
Y / N Epilepsy
Y / N Fainting/Dizziness
Y / N Gastrointestinal Disorders
Y / N Glaucoma
Y / N Headaches
Y / N Heart Defects/Disease/Murmur
Y / N Hepatitis/Liver Disease
Y / N Herpes
Y / N Face, Head, Neck, or Teeth Injuries
Y / N Difficulty chewing
Y / N Mouth ulcers/ sore gums
Y / N Teeth sensitive to hot and/ or cold
Y / N Suck thumb or have other habits
Y / N Grind teeth
Y / N Bite fingernails

Y / N High Blood Pressure/Low Blood Pressure
Y / N HIV/AIDS
Y / N Hospitalized
Y / N Immune Disorders
Y / N Kidney Disease
Y / N Lung Disease
Y / N Major Injuries
Y / N Neck Pain
Y / N Nervous Disorders
Y / N Other serious illness
Y / N Pneumonia
Y / N Radiation/Chemotherapy
Y / N Rheumatic Fever
Y / N Sinus Problems
Y / N Skin Disorder
Y / N Thyroid Disorders
Y / N Tuberculosis
Y / N TMD / Jaw problems
Y / N Vision, Hearing, Speech Problems
Y / N Tobacco Use: Cigarette/Chewing Tobacco
Y / N Early loss of any baby teeth
Y / N Usually breathe through mouth
Y / N Missing or extra permanent teeth
Y / N Play a wind instrument Type?_____
Y / N Endodontic work
Y / N Periodontal work
Y / N Permanent teeth removed

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

_____

_____

_____

What are the names and ages of 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.

Patient Signature:_____Relationship:_____Date:_____