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BUCKMAN

ORTHODONTICS



Please edit any incorrect information and fill out all of the blanks below.

Patient Name: _____ Nickname: _____

DOB: _____ Gender: _____

Address: _____ City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How would you like us to contact you during the day? (Circle one)

Home Work Cell Email

CHIEF CONCERN(s): _____

Who can we thank for referring you to this office? _____

Dentist Name: _____

Last Seen: _____

Are you currently under the care of a physician? Yes No

If so, for what reason(s)? _____

_____ Doctor Name: _____

Emergency Contact Information:

Name _____ Phone #: _____

Relation: _____

Patients Hobbies/Interests: _____

Responsible party: _____ DOB: _____

SSN: _____

Employer: _____

Insurance Company: _____

Insurance Phone: _____

Signature: _____

Date: _____

Relation to Patient: _____

Welcome to Buckman Orthodontics! Please complete the following health questionnaire as completely as possible and feel free to write additional information if necessary.

Please check the main concerns below:

- Crowding (crooked teeth)___
- Spacing ___
- Mouth too small ___
- Irregular shaped teeth ___
- Missing Teeth ___
- Impacted teeth ___
- Flared or Buck teeth ___
- Overbite ___
- Underbite ___
- Crossbite ___
- Openbite ___
- Gummy Smile ___
- Irregular facial proportions___
- Grind/clench teeth ___
- Clicking in jaw ___
- Ringing in ears ___
- Headaches ___
- Facial pain ___
- Neck pain ___
- Jaw pain ___
- Other _____

Other family members with same problems?_____

Patient's current physical health?
___ Good ___ Fair ___ Poor

Patient's current emotional health?
___ Good ___ Fair ___ Poor

Please list all medications taken by patient:

Medication	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- How often does the patient have dental checkups?
- ___ Once a year
- ___ Twice a year
- ___ More than twice a year
- ___ Only in an emergency
- ___ Never

Does the patient have a history of the following conditions?

- NONE**___
- AIDS/HIV ___
- Hepatitis ___
- Heart Disease/Murmur ___
- Kidney Disease ___
- Tuberculosis ___
- Mononucleosis ___
- Asthma ___
- Diabetes ___
- Prolonged Bleeding ___
- Anemia ___
- Endocrine Problems ___
- Epilepsy ___
- Tonsillitis ___
- Tonsils Removed ___
- Adenoids Removed ___
- Autoimmune disorder ___
- High Blood Pressure ___
- Low Blood Pressure ___
- Blood Disease ___
- Bone Disorder ___
- Cancer ___
- Dizziness ___
- Sleep Disturbance ___
- Snoring ___
- Eating Disorder ___
- Mouth-breathing ___
- Cleft lip/palate ___
- Head or Facial injury ___
- Emotional stress ___
- Nail biting ___
- Finger or thumb sucking ___
- Previous TMJ treatment ___
- Previous ortho treatment ___
- Plays musical instrument-Type: _____

Other: _____

- Allergy to drugs:** _____
- Allergy to Latex:** ___
- Allergy to Nickel** ___
- Allergies-Seasonal** ___
- Antibiotic Premedication** ___

Has the patient reached puberty?
___ No
___ Yes-Approx. date _____

Does the patient have difficulty chewing?
___ No ___ Yes-Describe_____

Has the patient been told they have a tongue thrust swallowing pattern?
___ No
___ Yes

Has the patient had a previous orthodontic exam/consultation?
___ No
___ Yes-When _____

What is the patient's interest in orthodontic treatment?
___ Wants treatment
___ Willing if necessary
___ Unwilling but agrees
___ Unwilling

Any additional information not already covered? _____

Patient Name _____

Signature of person completing form _____

Date _____

Relationship _____

**NOTICE OF HEALTH INFORMATION PRACTICES
ACKNOWLEDGEMENT FORM**



The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy carefully and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of Buckman Orthodontics. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Name of Patient

Signature of Patient or Guardian if patient is a minor

Date