Brett M. Buckman, DDS MS
Orthodontic Specialists for Children and Adults
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BUCKMAN ORTHODONTICS

American Association of Orthodontists

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: _____ Parent E-mail: _____

Cell Phone: _____

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 our office? _____

Dentist Name: _____ Last Seen: _____

Is the patient currently under the care of a physician? Yes No

If so, for what reason(s)? _____

Doctor Name: _____

Patients Hobbies/Interests: _____

Name of Father: _____ SSN: _____

Address: _____ DOB: _____

City, State, Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Cell Phone: _____

Insurance Phone: _____

Name of Mother: _____ SSN: _____

Address: _____ DOB: _____

City, State, Zip Code: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Insurance Company: _____ Cell Phone: _____

Insurance Phone: _____

Siblings not in treatment: **Date of Birth**

1. _____
2. _____
3. _____

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

BUCKMAN
ORTHODONTICS

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