



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

Patient Name: _____ DOB: _____

Nickname: _____ Gender: _____

Address: _____

Responsible Party Cell: _____

Responsible Party Email: _____

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

Doctor Name: _____

If yes, for what reason(s)? _____

Primary Responsible Party Name: _____ DOB: _____

Emergency Contact Name: _____

Relationship to Patient: _____

Cell: _____

Address (if Different than Patient): _____

Family/Siblings not in treatment: _____

Date of Birth

1. _____

2. _____

3. _____

Chief Complaint(s) _____

What aspect of orthodontic treatment are you most concerned with?

Quality: _____ Discomfort: _____

Cost: _____ Treatment Time: _____

No Concerns: _____

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 concern(s):

Crowding _____

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 _____

Ringling in ears _____

Headaches _____

Facial pain _____

Neck pain _____

Jaw pain _____

Other _____

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 for emergencies _____

Never _____

Allergies:

Allergy to drugs: Yes ____ No ____

If "Yes" What: _____

Allergy to latex: Yes ____ No ____

Allergy to nickel: Yes ____ No ____

Allergies - seasonal: Yes ____ No ____

Antibiotic premedication Yes ____ No ____

Did other family members have a similar problem(s)? Yes ____ No ____

If "Yes" Who: _____

Relationship to Patient: _____

Has the patient ever had any 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	_____
Bood disease	_____	Bone disorder	_____
Cancer	_____	Dizziness	_____
Seep disturbance	_____	Snoring	_____
Eating disorder	_____	Mouth breathing	_____
Cleft lip/palate	_____	Head or facial injury	_____
Emotional stress	_____	Nail biting	_____
Fnger or thumb sucking habit	_____	Other	_____

History of the following:

1. Difficulty chewing? Yes _____ No _____

If "Yes" describe: _____

2. Has the patient been told they have a tongue thrust swallowing pattern? Yes _____ No _____

If "Yes" describe: _____

Has the patient had a previous orthodontic consultation? Yes _____ No _____

If "Yes" When: _____

Has the patient had a previous TMJ treatment? Yes _____ No _____

If "Yes" When: _____

Has the patient had a previous orthodontic treatment? Yes _____ No _____

If "Yes" When: _____

Does the patient play a musical instrument?

Yes _____ No _____

If "Yes" What Instrument: _____

Has the patient reached puberty?

Yes _____ No _____

If "Yes" When: _____

What answer best describes the patient's interest in orthodontic treatment?

Eager for treatment _____

Unwilling, but agrees _____

Willing, if necessary _____

Unwilling _____

Any additional information not already covered?

Signature of Patient or Responsible Party

Date

Your electronic signature is the legal equivalent of a manual, handwritten signature.

Authorization for Cell Phone and Email Use

I give my consent to the provider to use my cell phone for appointments, treatment information, insurance, account and billing information, and special promotions. I understand that I can withdraw my consent at any time.

Signature of Patient or Responsible Party

Date

Your electronic signature is the legal equivalent of a manual, handwritten signature.

Photo Consent

I consent to the use of my or my child's photographs and x-rays for the purposes of marketing the practice of Buckman Orthodontics in the following mediums: Buckman Orthodontics website, social media (Facebook, Instagram, etc.), printed office brochures, newsletters, in-office displays, professional presentations, or journals.

Signature of Patient or Responsible Party

Date

Your electronic signature is the legal equivalent of a manual, handwritten signature.

Notice of Health information Privacy Practices

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.

Click to View: [Notice of Health Information Practices of Buckman Orthodontics](#)

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.

Signature of Patient or Responsible Party

Date

Your electronic signature is the legal equivalent of a manual, handwritten signature.