Dr. Buchanan Orthodontics

Patient Information

Date_________________________

Patient's Name ____ Male / Female

Last *First* *Middle*

Address ____

Street *City* *State* *Zip*

Date of Birth ____________ Home Phone ___________________ Cell/Work Phone ____________________

School __________________________ Grade ______ Hobbies/Interests ______________________________

General Dentist ____________________________ Family Physician _________________________________

Main reason for seeking treatment ____

Referred by ____________________________________

Responsible Party Information

Name ____

Last *First* *Middle* *Marital Status*

Address ____

Street *City* *State* *Zip*

How long at this address _______ Home Phone ____________________ Cell/Work Phone ____________________

Previous Address ____

(if less than 3 years) *Street* *City* *State* *Zip*

Date of Birth ____________ SSN ________________________ DL# ______________________________

Relationship to Patient __________________ E-mail ____

Employer _________________________ Occupation __________________________ # Years Employed _______

Spouse's Information

Spouse's Name ____

Last *First* *Middle*

Relationship to Patient __________________ E-mail ____

Spouse's Employer _____________________ Occupation ________________________ # Years Employed _______

Date of Birth ____________ SSN ________________________ DL# ______________________________

Insurance Information

Insured's Name _______________________ Date of Birth _____________ Insured's SSN ___________________

Employer _________________________________ Insurance Co. ___________________________________

ID/Member # ____________________ Group # _______________________ Phone # ___________________

Emergency Information

Name of nearest relative not living with you ____

Relationship to Patient ________________________ Phone ____

Address ____

Street *City* *State* *Zip*

Signature *(Parent's signature, if minor)* ____

I understand that were appropriate, credit bureau reports may be obtained. *Date*

Welcome to our office!

Patient's Name ____ Date ____________________

Medical History

Adult females: Are you pregnant? .... Y / N

Are you in good health? .... Y / N (If no, explain) ______________________________

Do you have any major or unusual illness? .... Y / N (If yes, explain) ______________________________

Are you currently being treated by a physician? .. Y / N (If yes, explain) ______________________________

Do you have any allergies? .... Y / N (If yes, explain) ______________________________

Do you have any drug sensitivity? .... Y / N (If yes, explain) ______________________________

Do you have, or have had, any of the following:

- ☐ Anemia
- ☐ Blood disease
- ☐ Prolonged bleeding
- ☐ Jaundice
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Hepatitis
- ☐ Glaucoma
- ☐ Heart problems
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Endocrine Problems
- ☐ Bone disorders
- ☐ Epilepsy
- ☐ Herpes
- ☐ Frequent colds/flu
- ☐ Frequent tonsillitis
- ☐ Tonsils removed: Age___________
- ☐ Adenoids removed: Age_________
- ☐ Asthma
- ☐ Mouth Breathing: Awake / Asleep
- ☐ H I V positive

Names and birthdates of brothers/sisters or children? ______________________________

____

Have any family members had orthodontic treatment? ______________________________

____

Dental History

Please check any that apply:

- ☐ Any head, face, or tooth injuries? Explain: ______________________________
- ☐ History of thumb/finger sucking? Is the habit still present? Y / N If no, stopped at what age? __________
- ☐ Previous orthodontic consultation or treatment? If so, when? ______________________________
- ☐ Any speech problems? Explain: ______________________________
- ☐ Clenching of teeth?
- ☐ Muscular soreness? (head / neck)
- ☐ Jaw soreness?
- ☐ Ringing in the ears?
- ☐ Grinding of teeth?
- ☐ Frequent headaches?
- ☐ Jas clicking/popping?
- ☐ Difficulty opening/closing?

Is there anything else that you feel we should know about you/the patient that may be helpful for consultation/treatment? ___________

____

Signature ____

Date

Thank You! We're glad you're here!