BUCHART ORTHODONTICS
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# WELCOME TO OUR ORTHODONTIC OFFICE

The benefits of a happy, healthy smile are immeasurable! A beautiful smile is a wonderful asset. Please fill out this form COMPLETELY.

## PATIENT INFORMATION

Today's Date:_____
Name:_____
I prefer to be called:_____
Birth Date:_____ Age:_____
Social Security #:_____
Home Address:_____
City:_____State:_____Zip:_____
Home #:_____Cell#:_____
Work #:_____Ext#:_____
Email:_____
Best Place to reach you:_____
Would you like to receive email appointment reminders? YES___NO____
Employer:_____
Employer's Address:_____
City:_____State:_____Zip:_____
Occupation:_____
Time at Current Employer:_____
Whom should we thank for referring you:
_____
Other family members seen by us:
_____

## SPOUSE INFORMATION

Name:_____
Employer:_____
Work #:_____
Social Security #:_____
Birth Date:_____

## RESPONSIBLE PARTY

Name:_____
Billing Address:_____
City:_____State:_____Zip:_____
Home#:_____Cell #:_____
Work#:_____Ext#:_____
Email:_____
Relation to Patient:_____
Social Security #:_____

## PRIMARY DENTAL INSURANCE

Orthodontic Coverage: YES___NO____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group Policy #:_____
Insured Name:_____
Relationship to Patient:_____
Insured's Birth Date:_____
Insured Social Security #:_____
Insured's Employer:_____

## SECONDARY DENTAL INSURANCE

Orthodontic Coverage: YES___NO____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #:_____
Group Policy #:_____
Insured Name:_____
Relationship to Patient:_____
Insured's Birth Date:_____
Insured Social Security #:_____
Insured's Employer:_____

## IN THE EVEN OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

Name:_____
Relation:_____
Home#:_____Cell#:_____
Work#:_____Ext#:_____

## MEDICAL INFORMATION

General Dentist:_____
Date of Last Visit:_____

General Physician:_____
Date of Last Visit:_____
Phone #:_____

## MEDICAL HISTORY

Your current physical health is: Good Fair Poor
Are you currently under the care of a physician? Yes No
If yes, please explain:_____
Are you taking any prescription or over-the-counter drugs? Yes No
Please list:_____
_____

For Women:
Are you taking birth control pills? Yes No
Are you pregnant? Yes No
If yes, Week #_____
Are you nursing? Yes No

## HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

| | |
|---|---|
| Y N Anemia/ Radiation Treatment | Y N Artificial Bones/ Joints |
| Y N Artificial Valves | Y N Asthma/ Arthritis |
| Y N Blood Transfusion | Y N Cancer/ Chemotherapy |
| Y N Congenital Heart Defect | Y N Diabetes/ Tuberculosis (TB) |
| Y N Difficulty Breathing | Y N Drug/ Alcohol Abuse |
| Y N Emphysema/ Glaucoma | Y N Epilepsy/ Seizures |
| Y N Fever Blisters/ Herpes | Y N Heart Attack/ Stroke |
| Y N Heart Murmur | Y N Heart Surgery/ Pacemaker |
| Y N Hemophilia | Y N Hepatitis |
| Y N High/ Low Blood Pressure | Y N HIV+/ AIDS |
| Y N Hospitalized for Any Reason | Y N Kidney Problems |
| Y N Mitral Valve Prolapse | Y N Psychiatric Problems |
| Y N Rheumatic/ Scarlet Fever | Y N Severe/ Frequent Headaches |
| Y N Shingles | Y N Sinus Problems |
| Y N Ulcers/ Colitis | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had:
_____
_____

## ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

| | |
|---|---|
| Y N Aspirin | Y N Any Metal/ Plastic |
| Y N Codeine | Y N Dental Anesthetics |
| Y N Erythromycin | Y N Penicillin |
| Y N Tetracycline | Y N Other |

**ARE YOU ALLERGIC TO LATEX? Yes No**
Please list any other drugs that you are allergic to:
_____

## WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHDONTICS TO ADDRESS?

_____
_____
_____

## DENTAL HISTORY

Have you ever been evaluated for Orthodontic Treatment? Yes No
Have you ever had a serious/ difficult problem associated with any previous dental work? Yes No
**Do you now, or have you ever experienced pain/ discomfort in your jaw joint (TMJ/ TMD)?** Yes No
Your current dental health is Good Fair Poor
Do you like your smile? Yes No
Do your gums bleed easily? Yes No
Have you ever had an injury to your Mouth Teeth Chin
Do you have any speech problems? Yes No
Do you generally breathe through your mouth? Yes No
Do you have any missing/ extra permanent teeth? Yes No
Do you smoke? Yes No
How often do you brush?_____
How often do you floss?_____
Other Comments:_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

**THANK YOU FOR FILLING OUT THIS FORM COMPLETELY**

This office reserves the right to verify the credit status of potential patients and/ or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

_____
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA