BUCHART ORTHODONTICS
MICHAEL P. BUCHART • DMD

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 (Under Age 18)

Today's Date:_____
Name:_____
I prefer to be called:_____
Birth Date:_____ Age:_____
Social Security #:_____
Home Address:_____
City:_____State:_____Zip:_____
Home #:_____Cell#:_____
Whom should we thank for referring you:
_____
Other family members seen by us:
_____

PARENT/ GUARDIAN INFORMATION

Name:_____
Birth Date:_____
Social Security #:_____
Email:_____
Best Place to reach you:_____
Would you like to receive email appointment reminders? YES___NO____
Employer:_____
Work#:_____Ext#:_____
Employer's Address:_____
City:_____State:_____Zip:_____
Occupation:_____
Time at Current Employer:_____

RESPONSIBLE PARTY FOR ACCOUNT

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

Patient's physical health is: Good Fair Poor
Is patient currently under the care of a physician? Yes No
If yes, please explain:_____
Is patient taking any prescription or over-the-counter drugs? Yes No
Please list:_____
_____

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

HAS PATIENT 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 the patient has ever had:_____
_____

IS PATIENT 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

IS PATIENT ALLERGIC TO LATEX? Yes No

Please list any other drugs that the patient is allergic to:
_____

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

_____
_____
_____

DENTAL HISTORY

Has patient ever been evaluated for Orthodontic Treatment? Yes No
Has patient ever had a serious/ difficult problem associated with any previous dental work? Yes No
Does patient now, or has patient ever experienced pain/ discomfort in jaw joint (TMJ/ TMD)? Yes No
Patient's dental health is Good Fair Poor
Does patient like their smile? Yes No
Do patient's gums bleed easily? Yes No
Has patient ever had an injury to their Mouth Teeth Chin
Does patient have speech problems? Yes No
Does patient generally breathe through their mouth? Yes No
Does patient have any missing/ extra permanent teeth? Yes No
Does patient smoke? Yes No
How often does patient brush?_____
How often does patient 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 of Parent/ Guardian 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 of Parent/ Guardian Date

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