BUCKS MONT
ORTHODONTICS

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PATIENT INFORMATION

Last Name	First Name	Nickname	SS #	Sex	Date of Birth	Age

Mailing Address	City	State	Zip	Home Phone

School Currently Attending	Grade	[] Single [] Married [] Sep [] Divorced [] Widow(er)	Email	Cell Phone

Employer	Employment Address	Business Phone	Other Phone

Referred by	Name of Dentist	Date of Last Visit to Dentist

Do you know a current or previous patient?	Names & Ages of Other Children

PARENT/PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT (complete if patient is a minor)

Father's Name	Mother's Name
Address (if different from patient's)	Address (if different from patient's)
City State Zip	City State Zip
Home Phone Work Phone	Home Phone Work Phone
Cell Phone Fax	Cell Phone Fax
SS # Email	SS # Email
Employer	Employer
Address	Address
City State Zip	City State Zip
If Divorce is Involved, Who is the Custodial Parent?	May Patient Information Be Released to the Non-Custodial Parent? [ ] Yes [ ] No

EMERGENCY CONTACT INFORMATION

Name of nearest relative, not living with you				Relationship to Patient

Mailing Address	City	State	Zip	Email

Cell Phone	Home Phone	Work Phone	Other phone

DENTAL INSURANCE INFORMATION

Insured's Name	Date of Birth	Insured's Social Security #

Insurance Company	Group#	Plan/Type

Insurance Phone #	Insured's Signature to assign benefits to Dr. Patel

Medical History

Physician_____ Date of Last Visit_____

Address_____ Phone_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Do you have a history of a major illness?_____
Yes No Have you had any major operations?_____
Yes No Do you require pre-medication prior to dental/medical procedures?_____

Check any of the medical conditions below that you have had or currently have.

○ Abnormal bleeding/ Hemophilia	○ Diabetes	○ Hepatitis/Liver problems	○ Pneumonia
○ Anemia	○ Dizziness	○ Herpes	○ Prolonged Bleeding
○ Arthritis	○ Epilepsy	○ High Blood Pressure	○ Radiation/Chemotherapy
○ Asthma or Hayfever	○ Gastrointestinal Disorders	○ HIV / Aids	○ Rheumatic Fever
○ Bone Disorders	○ Heart Problems	○ Kidney problems	○ Tuberculosis
○ Congenital Heart Defect	○ Heart Murmur	○ Nervous Disorders	○ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Dentist_____ Date of last visit_____

What concerns you most about your teeth? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth or teeth?_____
Yes No Is any part of your mouth sensitive to temperature or pressure?_____
Yes No Do your gums bleed when you brush?_____
Yes No Do you have any type of thumb or tongue habit?_____
Yes No Are you a mouth breather?_____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?_____
Yes No Has anyone in your family received orthodontic treatment here? If yes, who was it?_____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day?_____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears?_____
Yes No Are you aware that some appointments will be during school/work hours?_____

Female Patients Only:
Yes No Has menstruation started? _____

Yes No Are you pregnant?_____

Benefits of Orthodontics: Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Patel to perform a complete orthodontic evaluation.

Signature _____ Date _____

Print Name _____Relationship to Patient _____

Because We Want To Get To Know You...

What is/was your favorite subject in school?

_____

What is your favorite color?

_____

What kind of pet do you have?

_____

What was the last movie you saw?

_____

What are some of your hobbies?

_____

What is your favorite sports team?

_____

What is your favorite food?

_____

Who is your favorite superhero?

_____

What is something we can do to make your time with us more memorable?

_____

☺Thank you!!! ☺