BUMGARNER & MARTIN
ORTHODONTICS

Welcome

Date:_____

PATIENT'S INFORMATION

Your Name:_____Nickname: _____

Birth date:_____Age:_____ Male Female Single Married

Your Home Address:_____
STREET CITY STATE ZIP CODE

Your Home #: (_____)_____Your Cell #: (_____)_____

Your Work #: (_____)_____Your Email: _____

Current Employer:_____How long at current job? _____

Any relatives currently seeing us?_____

General Dentist:_____Last Dental Visit:_____

Referred to our office by: ☐ Website ☐ Dentist_____ ☐ School Advertisement
☐ Advertisement ☐ Friend_____ ☐ Google
☐ Other: _____

Person Responsible for Account: Same as above Name: _____

Home Address:_____
STREET CITY STATE ZIP CODE

Home #: (_____)_____Cell #: (_____)_____

Work #: (_____)_____Email:_____

Employer:_____How long at current job?_____

Family/Emergency Contact Information

Spouse's Name:_____

Employer:_____How long at current job?_____

Cell #: (_____)_____Work #: (_____)_____Email: _____

Emergency Contact (nearest relative not living with you):

Name:_____ Relation: _____

Address:_____
STREET CITY STATE ZIP CODE

Home #: (_____)_____ Work #: (_____)_____

PATIENT'S HEALTH HISTORY

Current physical health is (Please check one): ☐ Good ☐ Fair ☐ Poor

Does the patient have a personal/family physician?_____ Physician's Name: _____

Please list any prescriptions or over-the-counter medications presently being taken: _____

_____

Please list any allergies (particularly latex or metal): _____

For Women: Are you currently pregnant?_____ How far along?_____ Currently nursing? _____

For Children: Has puberty begun?_____ (Girls) Has menstruation begun?_____ If so, when? _____

Please check any of the following if the patient has, or has had….

☐ Arthritis	☐ Bone Disorders	☐ Heart Problems	☐ Diabetes
☐ Thyroid Problems	☐ Kidney Problems	☐ Hepatitis	☐ Liver Problems
☐ Anemia	☐ Handicaps/ Disabilities	☐ Epilepsy/Seizures	☐ Endocrine Problems
☐ Cancer	☐ Asthma/Difficult Breathing	☐ Blood Pressure Problems	☐ Heart Attack/Stroke
☐ ADD/ADHD	☐ AIDS/HIV+/Immune Disorders	☐ Autism/Developmental Disorder	☐ Tonsils/Adenoids Removed

☐ Have you ever or are you currently taking biophosphonates (Fosamax, Boniva, Actonel)?

Please list any other serious medical conditions: _____

Does the patient require pre-medication prior to dental visits? _____

Dental History

Has the patient ever been evaluated for orthodontic treatment before? _____

Does the patient visit their dentist regularly?_____ Brush regularly?_____ Floss Regularly? _____

Does any other close relative have similar arrangement of teeth or similar jaw appearance?

_____

What are your main concerns you would like orthodontics to accomplish?

_____

Please check any of the following if the patient has experienced…

☐ Injuries to face, mouth, teeth, chin (Circle)	☐ Any thumb, finger or lip sucking/biting habits (Circle)
☐ Mouth breathing while awake/asleep (Circle)	☐ Missing or extra permanent teeth (Circle)
☐ Speech problems, nail biting, tongue thrust (Circle)	☐ Sensitive or bleeding gums
☐ Had teeth removed by extraction? When? _____	
☐ Pain or tenderness in the jaw joint (TMJ/TMD)	☐ Clenching or grinding teeth
☐ Pain, popping, locking, when opening/closing jaw	☐ Muscle tenderness or stiffness in jaw or neck
☐ Severe or frequent headaches? How often per week? _____	
☐ Anxiety/nervousness at dental/medical appointments	☐ Strong gag reflex

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the orthodontic staff to perform the necessary orthodontic services the patient may need. This office reserves the right to verify credit status of potential patients prior to extending credit for treatment fees and may use the services of one or more credit reporting services. This office does not file insurance and I understand that I am responsible for making payments for services rendered.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE