



BUMGARNER & MARTIN
ORTHODONTICS

Welcome

Date: _____

PATIENT'S INFORMATION

Your Child's Name: _____ **Nickname:** _____

Birth date: _____ Age: _____ Male Female Current Grade: _____

Child's Home Address: _____
STREET CITY STATE ZIP CODE

Home #: (_____) _____ Current School: _____

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:

Name: _____ Relation: _____

Home Address: _____
STREET CITY STATE ZIP CODE

Home #: (_____) _____ Cell #: (_____) _____

Work #: (_____) _____ Email: _____

Employer: _____ How long at current job? _____

Family/Emergency Contact Information

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Home#: _____ Work#: _____ Home#: _____ Work#: _____

Cell #: _____ Email: _____ Cell #: _____ Email: _____

Employer: _____ Years there? _____ Employer: _____ Years there? _____

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...

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Handicaps/ Disabilities | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma/Difficult Breathing | <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> Heart Attack/Stroke |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AIDS/HIV+/Immune Disorders | <input type="checkbox"/> Autism/Developmental Disorder | <input type="checkbox"/> 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...

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