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Orthodontic Specialists for Children and Adults
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Please edit any incorrect information and fill out all of the blanks below.

Patient Name: _____
Nickname: _____
Patient SSN: _____
Address: _____
City, State, Zip Code: _____
Home Phone: _____
Cell Phone: _____
DOB: _____
Gender: _____
Work Phone: _____
Email Address: _____
How would you like us to contact you during the day? (Circle one)
Home Work Cell Email

Dentist Name: _____
Doctor Name: _____
Last Seen: _____
Last Seen: _____
Is the patient currently under the care of a physician? Yes No
If so, for what reason(s)? _____

Who can we thank for referring you to this office? _____
Chief Complaint(s): _____

Patients Hobbies/Interests: _____

If Patient is a Minor:

Name of Father: _____
Address: _____
City, State, Zip Code: _____
Employer: _____
Insurance Company: _____
Group Number: _____
Address: _____
City, State, Zip Code: _____
SSN: _____
DOB: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Insurance Phone: _____

Name of Mother: _____
Address: _____
City, State, Zip Code: _____
Employer: _____
Insurance Company: _____
Group Number: _____
Address: _____
City, State, Zip Code: _____
SSN: _____
DOB: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Insurance Phone: _____

Siblings' name/s: First	Last	Date of Birth
1.	_____	_____*
2.	_____	_____*
3.	_____	_____*
4.	_____	_____*
5.	_____	_____*

Signature _____ Date _____
Relation to Patient _____

(CREDIT INFORMATION WILL BE REVIEWED THRU EXPERIAN CREDIT DATA)

Patient Name: _____

Welcome to Buckman Orthodontics! Please complete the following health questionnaire as completely as possible and feel free to write additional information if necessary.

Please check the main concerns below:

- Crowding
- Overbite
- Protrusion of teeth
- Misalignment
- Receding Jaw
- Prominent Jaw
- Gummy Smile
- Spacing
- Gum Disease/Recession
- Missing Teeth
- Jaw Dysfunction
- Mouth too small
- Clicking in jaw
- Irregular shaped teeth
- Ringing in ears
- Headaches
- Facial pain
- Neck pain
- Jaw pain
- Irregular facial proportions
- Crossbite
- Underbite
- Openbite
- Impacted teeth

Other family members with same problems? _____

Patient's current physical health?
 Good Fair Poor

Patient's current emotional health?
 Good Fair Poor

Please list all medications taken by patient:
 Heart pills, digitalis
 Antibiotics
 Pain pills
 Birth control pills
 Muscle relaxants
 Anti-anxiety/antidepressants
Others, Name _____

How often does the patient have dental checkups?
 Once a year
 Twice a year
 More than once a year
 Only in an emergency
 Never

Does the patient have a history of the following conditions?
AIDS/HIV
Hepatitis
Heart Disease/Murmur
Kidney Disease
Tuberculosis
Mononucleosis
Asthma
Diabetes
Prolonged Bleeding
Allergies
Anemia
Endocrine Problems
Epilepsy
Tonsillitis
Tonsils Removed
Adenoids Removed
Autoimmune disorder
High Blood Pressure
Low Blood Pressure
Blood Disease
Cancer
Dizziness
Sleep Disturbance
Snoring
Eating Disorder
Mouth-breathing
Allergies:Seasonal
Allergy to drugs: _____
Allergy to Latex:
Allergy to Nickel
Head or Facial injury
Antibiotic Premedication
Finger or thumb sucking
Nail biting
Plays musical instrument-Type: _____

Previous TMJ treatment
Previous ortho treatment
Cleft lip/palate
Emotional stress
Other-Describe _____

Has the patient reached puberty?
 Yes-Approx. date _____
 No
Does the patient have difficulty chewing?
 Yes-Describe _____

 No

Does the patient have pain/clicking in the jaw joints?
Yes: Right, Left, Both
 No

Does the patient grind/clench teeth?
 Yes
 No
 Unsure

Has the patient been told they have a tongue thrust swallowing pattern?
 Yes
 No

Has the patient had a previous orthodontic exam/consultation?
 Yes:When _____
 No

What is the patient's interest in orthodontic treatment?
 Wants treatment
 Willing if necessary
 Unwilling but agrees
 Unwilling

Any additional information not already covered? _____

Signature _____
Relationship _____

Date _____

PRIVACY CONSENT

We have elected to use this optional form under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to beginning your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e. individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e. performance reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a complete copy of which is available for your review.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the complete Privacy Policy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised note.

You may revoke this Consent at any time by submission in writing. However, such revocation will not be effective to the extent that any action has previously been taken in accordance with this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Name

Patient's Signature (if 18 or over)

Parent or Guardian

Parent or Guardian's Signature

Date