

Brett M. Buckman, DDS MS  
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