Welcome to Bruner Orthodontics! Please fill out our orthodontic acquaintance form.

PLEASE PRINT

Patient's Name _____ Date_____

Nickname _____ Sex ____ Age_____ Birthdate _____

Address _____

City _____ Zip_____ Home Email _____

Cell Phone_____ Home Phone _____Other Phone-_____

Employed By _____ Work Phone _____

Dental Ins. Co _____ Dental ID #_____ Group # _____

Person Responsible for account _____SS#_____

Address _____

Patient's Dentist _____ Date of Last Cleaning_____

Referred By _____

Family history of orthodontics _____

Medical and Dental History

Describe Your Health _____

Do you have any medical problem we should know about? Yes_____ No ____ If yes, please describe

_____

Your Physician _____

Do you take any medications? Please list _____

Do you have any known allergies? If yes please list _____

Female patients: Are you pregnant? Yes___ No___

Have there been any injuries to face, mouth or teeth? Yes ____ No ____ If yes, please describe

_____

Have you have or had any of the following?

Sleep Apnea	Y N	Hepatitis	Y N	Herpes/Canker Sores	Y N
Heart Trouble	Y N	Epilepsy	Y N	Prolonged Bleeding	Y N
Glaucoma	Y N	Nervous Disorders	Y N	Anemia	Y N
Rheumatic Fever	Y N	Fainting or Dizziness	Y N	Allergies	Y N
Diabetes	Y N	Asthma	Y N	AIDS or HIV Positive	Y N
History of Drugs or Alcohol	Y N				

Are you a mouth breather? Yes _____ No _____ Tongue thruster? Yes____ No____

What is the reason for seeking orthodontic treatment? _____

_____

Responsible Party Signature