duvallorthodontics
delivering smiles

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**