CONFIDENTIAL INFORMATION
Date _____

UNDER 18
PATIENT INFORMATION FORM

Welcome to our Office...
Please assist us by completing the following questions...

Whom may we thank for your referral?_____

PATIENT INFORMATION				
Last Name	First	Middle	Preferred Name	
Address				
City	State	Zip Code		
Home Phone	Date of Birth	Age	Sex: Male ☐ Female ☐	S.S.N.
Favorite Sports, Hobbies & Avocations				
Brothers/Sisters Name(s)	Age(s)			
School Attending	Grade	Musical Instrument(s) played		

RESPONSIBLE PARTY INFORMATION			
Name of Person Responsible for Account		Relationship to Patient	
Father's Name	Address *(If different from above)*	DOB	S.S.N.
Employed by		Work Phone	CELL #
Mother's Name	Address *(If different from above)*	DOB	S.S.N.
Employed by		Work Phone	CELL #
Do you have Dental Insurance? ☐ Yes ☐ No	*(If Yes, please provide us with a copy of your insurance card)*		
In case we cannot reach you, person(s) to contact		Phone Number	

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing orthodontic treatment. All information will be kept completely confidential.

MEDICAL HISTORY

Physician's Name:_____
Address:_____ Phone: _____

Is the patient in good health? ☐ Yes ☐ No Explain:_____
Does the patient have a history of a major illness? ☐ Yes ☐ No Explain:_____
Is the patient under the care of a physician? ☐ Yes ☐ No Explain:_____

Is the patient taking any medications? ☐ Yes ☐ No List:_____
Is the patient allergic to: ☐ penicillin ☐ codeine ☐ local anesthetics ☐ banthine
Is the patient allergic or sensitive to any other drugs, foods, metals or other products (i.e. latex, nickel)? ☐ Yes ☐ No List:_____

Has the patient had surgery that involves the placement of a prosthesis (i.e. hip/knee replacement, heart valve, etc.)? ☐ Yes ☐ No Describe:_____
Has the patient had surgery or radiation treatment for a tumor or growth in the head and neck area? ☐ Yes ☐ No Describe:_____

Onset of puberty (approximate date)? _____

(Boys) Has voice changed? ☐ Yes ☐ No

(Girls) Has menstruation begun? ☐ Yes ☐ No

Patient's Height_____ Patient's Weight_____ Mother's Height_____ Father's Height_____

Cont'd...please complete the reverse side

Please check if you have had any of the following conditions:

☐ HIV Positive/AIDS	☐ Tuberculosis	☐ Allergies	☐ Stomach Ulcers	☐ Endocrine Problems
☐ Hepatitis Type____	☐ High/Low B.P.	☐ Asthma/Lung Disease	☐ Gastric Reflux	☐ Nervous Disorders
☐ Liver Disease/Jaundice	☐ Diabetes	☐ Cancer	☐ Polio	☐ Bone Disorders
☐ Rheumatic Fever	☐ Bleeding Problems	☐ Anemia	☐ Mononucleosis	☐ Facial Pain
☐ Rheumatic Heart Dis.	☐ Lung Disease	☐ Glaucoma	☐ Substance Abuse	☐ Bulimia
☐ Scarlet Fever	☐ Epilepsy/Seizures	☐ Degenerative Joints	☐ Migraine Headaches	☐ Anorexia Nervosa
☐ Heart Murmur	☐ Arthritis	☐ Thyroid Problems	☐ Emotional Problems	☐ Muscular Disorder
☐ Heart Trouble/Surgery	☐ Lupus/CT Disease	☐ Venereal Disease	☐ Stroke	☐ Fainting Spells
☐ Heart Valve Defects	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ Frequent Headaches	☐ Other_____

COMMENTS:_____

_____

DENTAL HISTORY

Dentist's Name:_____

Address:_____ Phone:_____

Please check any of the following conditions for which you have been diagnosed or treated:

☐ Facial/Teeth/Jaw Injury	☐ Tongue Thrust	☐ Dead Teeth/Root Canal	☐ Ringing in the Ears	☐ Mouth Breathing
☐ TMJ/TMD/Jaw Problems	☐ Bleeding Gums	☐ Tooth Sensitivity	☐ Cold Sores	☐ Impacted Teeth
☐ Grinding/Clenching Habit	☐ Receding	☐ Chipped or Broken Teeth	☐ Mouth Ulcers	☐ Receding Jaw
☐ Jaw Clicking/Popping	☐ Gum Disease	☐ Thumb or finger habit	☐ Jaw Cysts/Tumors	☐ Other_____
☐ Jaw Locking	☐ Lip Habit	☐ Facial Pain	☐ Missing Teeth	☐ Other_____

COMMENTS:_____

_____

Which of the following are significant concerns?

☐ Crooked/Crowded Teeth	☐ Over Developed Jaw	☐ Missing Teeth
☐ Impacted Teeth	☐ Tooth Wear	☐ Protruding Teeth
☐ Spaced Teeth	☐ Extra Teeth	☐ Overbite
☐ Under Developed Jaw	☐ Wisdom Teeth	☐ Other_____

What would you change about your teeth or smile?_____

Have you had a prior orthodontic exam or prior orthodontic treatment? ☐Yes ☐No

Are you currently under a general dentist's care? ☐Yes ☐No

When was your last dental exam and cleaning? _____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

If so, please explain: _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

_____ _____

Signature of Patient or Guardian Date

CONSENT FOR DIAGNOSTIC RECORDS

I consent to the taking of x-rays, models and photographs necessary for diagnostic purposes.

_____ _____

Signature of Patient or Guardian Date

INSURANCE AUTHORIZATION

I agree to be responsible for dental services and materials not paid by my dental benefit plan and to the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____

Signature of Patient or Guardian Date

CONSENT FOR WEBSITE PHOTO

I consent to allow my child's picture to be displayed on the busbywebb.com website.

_____ _____

Signature of Parent or Guardian Date