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

PLEASE PRINT

Patient's Name ____ Date______________________________

Nickname _______________________ Sex ____ Age_____ Birthdate _________________________

Address ____ Home Phone ______________________

City _____________________________________ Zip______ Home Email ______________________

Employed By ____ Work Phone ______________________

SS#____________________________ Ins. Co._______________ Group # _________________________

Person Responsible for account ____

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?

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
Herpes/Canker Sores	Y	N	Hepatitis	Y	N	History of Drugs or Alcohol	Y	N

Have you been informed of missing or extra teeth? ____

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

What is the reason for seeking orthodontic treatment? ____

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Responsible Party