Welcome to Bruchal Orthodontics!

PATIENT INFORMATION

Full Name: _____ Nickname: _____
First MI Last

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home _____ Mobile _____ Work _____

email: _____

Preferred Primary Contact: ☐ eMail ☐ Text ☐ Mail ☐ Phone

Marital Status: ☐ Married ☐ Single ☐ Separated/Divorced ☐ Widowed

If married, spouse's Name: _____ Phone: _____

INSURANCE INFORMATION

If you would like us to consider your insurance benefits, please provide us with your insurance information and card.

Primary Insurer: _____ Employer: _____

Policy No.: _____ Group No.: _____ Member ID: _____

Insured's Full Name: _____
First MI Last

Gender: ☐ Male ☐ Female Date of Birth: _____ Relationship to Patient: _____

Secondary Insurer: _____ Employer: _____

Policy No.: _____ Group No.: _____ Member ID: _____

Insured's Full Name: _____
First MI Last

Gender: ☐ Male ☐ Female Date of Birth: _____ Relationship to Patient: _____

All of the information you provide will remain confidential as described in our Notice of Privacy Practices.

MEDICAL HISTORY

Patient: _____

Physician _____ Date of Last Visit _____

Patient experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in patient's health recently? ☐ No ☐ Yes Explain: _____
Patient currently under a physician's care? ☐ No ☐ Yes Explain: _____
Patient taking any medications? ☐ No ☐ Yes List: _____
Any known allergies to any medications or substances? ☐ No ☐ Yes List: _____
Patient had any operations? ☐ No ☐ Yes Explain: _____
Female Patients only: Are you pregnant? ☐ No ☐ Yes How far along? _____

Has the patient ever had any of the following conditions?:

No	Yes		No	Yes		No	Yes	
☐	☐	Heart Murmur	☐	☐	Hepatitis	☐	☐	Emotional Problems
☐	☐	Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Nervous/Anxious
☐	☐	Congenital Heart Defect	☐	☐	Kidney Disease	☐	☐	Frequent Headaches
☐	☐	Heart Surgery	☐	☐	Diabetes	☐	☐	Bone Disorders
☐	☐	Prolonged Bleeding	☐	☐	Endocrine Disorder	☐	☐	Growth Disorders
☐	☐	Blood Disorder	☐	☐	Tuberculosis (TB)	☐	☐	Radiation/Chemotherapy
☐	☐	Anemia	☐	☐	Asthma	☐	☐	Cancer/Tumor
☐	☐	Blood Pressure (High/Low)	☐	☐	Epilepsy	☐	☐	Herpes
☐	☐	Artificial bones/joints	☐	☐	Fainting	☐	☐	HIV / AIDS
☐	☐	Gastrointestinal Disorders	☐	☐	ADD/ADHD	☐	☐	Tonsillitis

Are there any other medical conditions we need to be aware of? _____

Growth Information for Patients Under 16 Years of Age - Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are necessary to aid in the selection of treatment options.

Has your son or daughter reached puberty? ☐ No ☐ Yes
Girls - Has she started menstruation? ☐ No ☐ Yes When? _____
Boys - Has his voice changed? ☐ No ☐ Yes When? _____
Patient's Height_____ Do you feel growth is completed? ☐ No ☐ Yes
Father's Height_____ Mother's Height_____ Adopted? ☐ No ☐ Yes
Have either siblings or parents had orthodontic treatment? ☐ No ☐ Yes Who? _____

DENTAL HISTORY

General Dentist _____ Phone no. _____

Dental Specialist _____ Phone no. _____

Frequency of dental checks: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never Date of last visit _____

How often does patient brush? _____ How often does patient floss? _____
Is there any unfinished dental work to be completed by the dentist? ☐ No ☐ Yes Explain: _____
Does the patient require antibiotics before dental treatment? ☐ No ☐ Yes Explain: _____
Has the patient had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes Explain: _____
Has the patient been informed of any missing or extra permanent teeth? ☐ No ☐ Yes Explain: _____
Have there been any injuries to the face, mouth, teeth or chin? ☐ No ☐ Yes Explain: _____
Has the patient consulted an orthodontist previously? ☐ No ☐ Yes With whom and when? _____
Has the patient had any previous orthodontic treatment? ☐ No ☐ Yes With whom and when? _____
Has anyone in the patient's family received orthodontic treatment? ☐ No ☐ Yes Explain: _____
Any changes in the patient's bite or dental alignment recently? ☐ No ☐ Yes Explain: _____

Any history of:

No	Yes		No	Yes		No	Yes	
☐	☐	Clenching teeth	☐	☐	Muscular soreness around head/neck	☐	☐	Nail biting
☐	☐	Grinding teeth	☐	☐	Jaw joint soreness/pain	☐	☐	Tongue thrust
☐	☐	Jaw joint clicking/popping	☐	☐	Thumb/finger sucking	☐	☐	Mouthbreathing:
☐	☐	Speech problems (which sounds)_____	☐	☐	Lip sucking/biting			Awake _____
☐	☐	Headaches (more than usual)						Asleep _____

Describe the orthodontic problem in your own words: _____

I understand that the information that I have given is correct to the best of my knowledge and I agree to inform this office of any changes in medical or dental history. I also understand that the patient's diagnostic records may be used for lecturing, publishing, or educational purposes. In addition, I authorize Dr. Bruchal to perform a complete orthodontic evaluation.

Signature: _____ Printed Name: _____ Date _____

All information will be kept completely confidential. Please inform us if any changes should occur.

Acknowledgement of Receipt of Notice of Privacy Practices

The Notice of Privacy Practices describes the types of uses and disclosures of the patient's protected health information that might occur related to the patient's treatment, payment for services, or in the performance of office health care operations. The Notice of Privacy Practices also describes the patient's rights and the responsibilities and duties of this office with respect to the patient's protected health information.

Bruchal Orthodontics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Bruchal Orthodontics.

_____ _____

Signature of Patient or Parent/Guardian Date

_____

Patient's Name