# Brunk and Laster Orthodontics

A B C D E

Today's Date: __________________

## Patient Information

Patient's Name:

______________________________________________________________________________

Last First Middle

Address:

______________________________________________________________________________

Street City State Zip

Home Phone: __________________ Birth date: ________________ Name patient likes to be called: ________________________

Whom can we thank for referring you to our office? ________________________________________________________________

Other Family members treated: ________________________________________________________________________________

## Responsible Party Information

Name: ______________________________________________________________________ Marital Status: _______________

Last First Middle

Address: (If different from above)

__________________________________________________________________________

Street City State Zip

Home Phone: __________________________ Social Sec. #:______________________ Date of Birth: _____________________

Employer: _________________________________________ Work #: ____________________ Cell #:____________________

Spouse Name: __________________________________ SS#:_______________________ Work # _______________________

Spouse employer: _____________________________ Date of birth: ___________________ Cell #: _______________________

Primary Email address: ______________________________________________________
(This will allow us to email you appointment reminders and allow you 24 hour access to your personal account information.)

## Dental Insurance Information

Insured's Name: __________________________________________________ SS #:________________________________

Date of Birth: ____________________________

Employer: ________________________________________ Occupation: ______________________________

Insurance Company Name: ___________________________________________ Group #: _______________

Insurance Co. Address: __________________________________________________________________

Insurance Co. Phone #: ________________________________________

If you have dual coverage our office will provide you with the paper work needed for the secondary plan. You will be responsible for filing this claim separately and will make the benefits payable directly to you.

I hereby authorize release of any information relating to this claim and payment of insurance benefits to be paid directly to the above named orthodontist.

__________________________________________________________________________

Signature

Date

## Emergency Contact Information:

Name of nearest contact person not living with you: ________________________________________________

Address: _____________________________________________________________________________

Phone: _________________________________________ Relationship to you: ____________________

I understand that were appropriate, credit bureau reports may be obtained.

Signature: (Parents if patient is a minor)

________________________________________________________________

Updates: (Date and initial please) ____________________ ____________________ ____________________

## Medical History

Has the patient ever been treated for any of the following:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Diabetes……………… | □ | □ | Asthma……………………….. | □ | □ |
| Pneumonia…………… | □ | □ | Kidney Involvement………….. | □ | □ |
| Heart Trouble………… | □ | □ | Endocrine or Thyroid………… | □ | □ |
| Bone Disorders………. | □ | □ | Prolonged Bleeding…………... | □ | □ |
| Tuberculosis………….. | □ | □ | Liver Involvement …………… | □ | □ |
| Anemia……………….. | □ | □ | Fainting or dizziness………….. | □ | □ |
| Epilepsy………………. | □ | □ | Nervous Disorders……………. | □ | □ |

List any allergies: ____________________________________________________________________________

List any drugs or medications currently being taken and reasons:

__________________________________________

_____________________________________________________________________________________________

_
List history of any major illnesses:
______________________________________________________________
Have tonsils and adenoids been removed? ________ If so, at what age? _______________

**For Adolescent patients only:**
Growth in past 6 months: _________________ Has patient reached puberty? ________
Height: Patient: ______________ Mother: ______________ Father: _______________________
Patient's Physician: ______________________________________ Last seen: ________________

# Dental History

| | Yes | No |
|---|---|---|
| Has patient ever sucked thumb or finger? Until what age? ___________________________ | ☐ | ☐ |
| Have you been informed of any missing or extra permanent teeth? ____________________ | ☐ | ☐ |
| Does the patient clench or grind teeth? __________________________________________ | ☐ | ☐ |
| Is patient especially apprehensive toward dental visits? _____________________________ | ☐ | ☐ |
| Does the patient have any congenital abnormalities? _______________________________ | ☐ | ☐ |
| Has patient ever seen an orthodontist before? _____________________________________ | ☐ | ☐ |

Describe any injuries involving the face, mouth, or teeth:
___________________________________________________

Patient's Dentist: ________________________________________ Last seen: ____________________

# ALL STAR CLUB Fun Facts:

What school do you go to?
___________________________________________________________________________

What are some of your hobbies and interests?
____________________________________________________________

What is your favorite color?
__________________________________________________________________________

Do you have friends that already have their braces?
_______________________________________________________

Do you think you need braces? Why or why not?
_________________________________________________________

______________________________________________________________________________________________
____

Does having braces make you excited or nervous?
_________________________________________________________

Do you have your own email address?
____________________________________________________________________