Oaks Orthodontics

MAYS / BRUNO, DDS, MS

Dr. Matthew J. Bruno, D.D.S., M.S

Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY (Confidential)

Date _____

PATIENT INFORMATION

Patient Name _____ Prefer to be called _____
Birthdate _____/_____/_____ Age _____ Sex _____ Social Security # _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Home Phone ( ) _____ Work Phone ( ) _____
If student, Name of School, College _____City _____ State _____
Family / Friends Treated in this Office _____
Person to Contact in Case of Emergency_____ Phone ( ) _____
Occupation _____
Whom May We Thank For Referring You to Our Office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Home Phone ( ) _____Work Phone ( ) _____
Employer _____Years Employed _____Social Security # _____
Business Address _____ City _____ State _____ Zip _____
Person Responsible for Making Appointments: Name _____ Phone ( ) _____

ORTHODONTIC INSURANCE INFORMATION

Name of Insurance Company _____Policy # _____
Address _____ City _____ State _____ Zip _____
Policy Owner _____ Social Security # _____ Birthdate _____/_____/_____

PERSONAL INFORMATION

What is the main problem as you see it? _____
_____ _____
_____
Are you sensitive about the appearance of your teeth? _____ _____
Are you sensitive about the appearance of any facial features? (nose, chin, lips, etc.) _____
How do you feel about wearing braces? _____
_____
Has anyone in the family received orthodontic treatment? _____ Who? _____
What do you consider the main benefits of orthodontic correction?
Cosmetic ____ Functional ____ Psychological/Emotional ____ Other _____

MEDICAL

Physician's Name _____ Approximate date of last medical examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N ever been hospitalized
Y/N taking medication
Y/N allergic to medications
Y/N asthma
Y/N other allergies
Y/N hepatitis
Y/N other respiratory problems
Y/N mouth breathing
Y/N rheumatic fever
Y/N heart disease
Y/N heart murmur
Y/N anemia
Y/N prolonged bleeding
Y/N diabetes
Y/N arthritis
Y/N epilepsy
Y/N hormone therapy
Y/N psychological counseling

Updated

PLEASE EXPLAIN:

_____
_____
_____
_____
_____

DENTAL

Dentist's Name _____ Approximate date of last dental examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N apprehensive about dental care
Y/N discomfort from teeth
Y/N discomfort from gums
Y/N previous orthodontic therapy
Y/N frequent canker sores
Y/N previous thumb/finger sucking
Y/N thumb/finger presently active
Y/N speech therapy
Y/N injury involving teeth
Y/N injury to either jaw
Y/N frequent clenching of teeth
Y/N wake up with sore teeth
Y/N wake up with sore jaw
Y/N jaw joint sounds
Y/N jaw joint pain
Y/N jaw "tires" at mealtime
Y/N jaw catches when opening
Y/N jaw locks in closed position
Y/N facial pain
Y/N frequent headaches
Y/N neck or shoulder pain

PLEASE EXPLAIN:

_____
_____
_____
_____
_____

Signature _____ Date _____