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

Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY (Confidential)

Date ____________________________

PATIENT INFORMATION

Patient's Name ____ Prefers to be called ___________________________
Birthdate _____/_____/_____ Age __________ Sex __________ Social Security # __________ - ________ - ___________
Address _______________________________ City ______________________ State ______ Zip __________________
Home Phone ( ) ________________________________ Cell Phone ( ) ___________________________________
If student, Name of School __________________________________City ___________________ State _____________
Sibling(s) Treated in this Office ____
Person to Contact in Case of Emergency____________________________________ Phone ( ) ________________
Parents' Marital Status: Single Married Widowed Divorced Separated
Father's Name ___________________________ Home Phone ( ) ____________ Work Phone ( ) ______________
Address _______________________________ City ______________________ State ______ Zip __________________
Occupation ____
Mother's Name __________________________ Home Phone ( ) ____________ Work Phone ( ) ______________
Address _______________________________ City ______________________ State ______ Zip __________________
Occupation ____
Email address ____
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 ___________
Relationship to Patient (Please circle) Parent Step Parent Legal Guardian Other
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? ____
Has anyone in the family received orthodontic treatment? ______ Who? ____________________________________
How would you describe your child's temperament? ____
Is your child sensitive about the appearance of his/her teeth? ____
How does your child feel about wearing braces? ____
Patient's hobbies or interests ____

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 tonsils removed	Y/N prolonged bleeding	Y/N mouth breathing	Updated
Y/N taking medication	Y/N adenoids removed	Y/N diabetes	Y/N snores when sleeping	
Y/N allergic to medication	Y/N rheumatic fever	Y/N epilepsy	Y/N sounds "stuffy"	
Y/N asthma	Y/N heart disease	Y/N hormone therapy	Y/N frequent sore throats	
Y/N other allergies	Y/N heart murmur	Y/N emotional problem	Y/N abnormal growth problems	
Y/N hepatitis	Y/N anemia	Y/N arthritis		

PLEASE EXPLAIN:

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GENETIC

	YES	NO
Is the patient adopted?	Y	N
if so, does the patient know this?	Y	N
Has any member of the family had:		
A similar orthodontic condition?	Y	N
A similar facial appearance?	Y	N
A history of early or late puberty changes?	Y	N

PLEASE EXPLAIN:

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

PLEASE EXPLAIN:

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Signature ____ Date ____________________________