



M A Y S / B R U N O , D D S , M S

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

Signature _____ Date _____