Edward C. Bruno, D.D.S., M.S.D. **Board Certified Orthodontist for Children and Adults**

Confidential Patient and Family Information

We keep our families grouped together to assure more convenient appointment scheduling and application of family discounts. Please take a few minutes to complete all sections below. It's OK to skip the pink section if you have already completed it for another family member.

Patient' Name: _____ Gender: M ☐ F ☐ Date of Birth: _____
First Middle Initial Last mm dd yyyy

Nickname: _____ Hobbies/Sports _____

Address: _____ Home Phone: _____
Street City State Zip xxx xxx-xxxx

Cell Phone: _____ Cell Phone: _____
Whose phone: Patient? ☐ Mom? ☐ Dad? ☐ Spouse? ☐ Other? ☐ Whose phone: Patient? ☐ Mom? ☐ Dad? ☐ Spouse? ☐ Other? ☐

Email Address: _____ Email Address: _____

Family member	Relationship	Age	Family member	Relationship	Age

Who can we thank for inviting you to join our practice? _____

Confidential Account and Insurance Information

This information allows us to tailor payment plans for your orthodontic care and also to maximize your benefit from insurance. Please note that the covered person's information is needed to obtain an estimate of coverage from your dental plan. It will be held in strictest confidence.

Please skip any information that is the same as the patient information above.

Responsible party: _____ Marital Status Single ☐ Married ☐ Div. ☐ Sep. ☐ Partner ☐

Relationship to patient: _____

Residence _____ How long at this address? _____

Previous address (if less than 3 years at current address) _____

Mailing address (if different from residence) _____

Employer: _____ Occupation: _____ Years with this employer? _____

Contact Phone: _____ Work Phone: _____ OK to call? Y☐ N☐

Dental Insurance Information

Policy holder's name _____ Birthdate _____ SS# _____

Insurance Company: _____ Group # _____ ID# _____

Ins. Address: _____ Ins. Phone _____

Employer providing the policy _____ Is there dual coverage? Y ☐ N ☐

2nd Insurance Company _____ Group # _____ ID# _____

Ins. Address: _____ Ins. Phone _____

Employer providing the policy _____

I understand that a credit report may be requested for extended payment arrangements.

Signed: (parent if patient is a minor) _____ Date: _____

Edward C. Bruno, D.D.S., M.S.D. **Board Certified Orthodontist for Children and Adults**

Medical Questionnaire

Name of physician: _____ Daily Medications? Y☐ N☐

If yes, please list medications: _____

List serious illnesses or surgeries: _____

Y☐ N☐ Heart disease or abnormality?
Y☐ N☐ History of rheumatic fever?
Y☐ N☐ Heart murmur?
Y☐ N☐ Diabetes?
Y☐ N☐ Hepatitis?
Y☐ N☐ Anemia?
Y☐ N☐ Prolonged Bleeding Tendency?
Y☐ N☐ Arthritis?
Y☐ N☐ Thyroid or other metabolic problem?
Y☐ N☐ Smoking
Y☐ N☐ Frequent heartburn or gastric reflux
Y☐ N☐ Allergies (If yes, please list below)

Y☐ N☐ Cancer of any type?
Y☐ N☐ Radiation treatment or chemotherapy?
Y☐ N☐ Herpes or other STD?
Y☐ N☐ HIV or other immune system disorder?
Y☐ N☐ Mouth breathing?
Y☐ N☐ Frequent colds or ear infections?
Y☐ N☐ Frequent or severe headache?
Y☐ N☐ Depression, bipolar disorder?
Y☐ N☐ ADD or ADHD?
Y☐ N☐ Body dysmorphic disorder
Y☐ N☐ Snoring?
Y☐ N☐ Sleep Apnea?

Please list allergies → _____

Dental/Orthodontic Questionnaire

Name of dentist: _____ City: _____ Checkup within last 6 months Y ☐ N ☐

Y☐ N☐ Previous orthodontic treatment?
Y☐ N☐ Frequent of severe tooth decay?
Y☐ N☐ Gum problems or gum surgery?
Y☐ N☐ Feat of dentistry?
Y☐ N☐ Current dental pain?
Y☐ N☐ Permanent teeth extracted?
Y☐ N☐ Congenital absence of teeth?

Y☐ N☐ Clenching or grinding habit?
Y☐ N☐ Clicking or other noise in jaw joints?
Y☐ N☐ Pain in jaw joints (TMJ), chewing muscles or face?
Y☐ N☐ Thumb, finger or lip sucking habit at this time?
Y☐ N☐ History of such habits?
Y☐ N☐ History of injury to teeth or jaws?

Number of soft drinks, energy drinks or sugared hot drinks per day? ☐ 1 ☐ 2 ☐ 3 ☐ More Soft drink swishing habit? Y☐ N☐

Is this visit for a second orthodontic opinion? Y☐ N☐

Dental Injury? Office use only

What can we help you with? (Check <u>all</u> that apply.)

☐ Crowded or misaligned teeth
☐ Excess space between teeth
☐ Protruding teeth
☐ Problem with jaw size or position
☐ Appearance of front teeth
☐ Front teeth are too small
☐ Difficulty chewing
☐ Bite problems
☐ Too little tooth shows when smiling

☐ Head off a developing problem
☐ Self-consciousness about appearance of teeth
☐ Difficulty closing lips comfortably
☐ Slanted smile line
☐ Too much gum tissue shows in smile
☐ Missing teeth
☐ Worn or chipping teeth
☐ Dentist wants tooth movement to help with restorations

Signed: (parent if patient is a minor): _____ Date: _____