



bruner
orthodontics
compassionate hearts • outstanding results

Welcome to Bruner Orthodontics! Please fill out our orthodontic acquaintance form.

PLEASE PRINT

Patient's Name _____ Date _____

Nickname _____ Sex ____ Age _____ Birthdate _____

Address _____

City _____ Zip _____ Home Email _____

Cell Phone _____ Home Phone _____ Other Phone- _____

Employed By _____ Work Phone _____

Dental Ins. Co _____ Dental ID # _____ Group # _____

Person Responsible for account _____ SS# _____

Address _____

Patient's Dentist _____ Date of Last Cleaning _____

Referred By _____

Family history of orthodontics _____

Medical and Dental History

Describe Your Health _____

Do you have any medical problem we should know about? Yes ____ No ____ If yes, please describe

Your Physician _____

Do you take any medications? Please list _____

Do you have any known allergies? If yes please list _____

Female patients: Are you pregnant? Yes ____ No ____

Have there been any injuries to face, mouth or teeth? Yes ____ No ____ If yes, please describe

Have you have or had any of the following?

Sleep Apnea	Y N	Hepatitis	Y N	Herpes/Canker Sores	Y N
Heart Trouble	Y N	Epilepsy	Y N	Prolonged Bleeding	Y N
Glaucoma	Y N	Nervous Disorders	Y N	Anemia	Y N
Rheumatic Fever	Y N	Fainting or Dizziness	Y N	Allergies	Y N
Diabetes	Y N	Asthma	Y N	AIDS or HIV Positive	Y N
History of Drugs or Alcohol	Y N				

Are you a mouth breather? Yes ____ No ____ Tongue thruster? Yes ____ No ____

What is the reason for seeking orthodontic treatment? _____

Responsible Party Signature