BURTON ORTHODONTICS

Brian J. Burton, DMD, MS, PC

Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Birthdate: _____ Sex: _____ Age: _____

Who is your General Dentist?: _____ Grade and School: _____

How did you hear about our office?: _____ Siblings? Name and DOB: _____

Email: _____ _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status

Social Security# _____ Relationship to Patient:_____

BirthDate: _____

Please circle: Own/Rent

How long at this address? _____ Home Phone: _____ Work/Cell Phone: _____

Mailing Address (if different from above):_____
Street City State Zip

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Work/Cell phone:_____
Last First Middle

Employer: _____ Occupation: _____ No. Years Employed: _____

Social Security #_____ Birthdate:_____ Email:_____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ SS or ID#: _____ Birthdate:_____

Insurance Co.: _____ Group #: _____ Telephone#: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

Do you have dual coverage? Yes No If yes:

Insured's Name: _____ SS or ID#: _____ BirthDate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

DENTAL HISTORY

What are the main goals you would like orthodontics to accomplish?

_____

_____

_____

_____

_____

How many months has it been since your last dental check-up? _____

Have you ever had a negative dental experience? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you been evaluated or had orthodontic treatment? Y N

Have you ever injured your face, mouth, teeth or chin? Y N

Have your adenoids or tonsils been removed? Y N

Do you have any missing , extra, or impacted teeth? Y N

Have you ever had any pain or tenderness in your jaw- Y N

joint (TMJ/TMD)? Y N

Do you take any prescriptions or OTC drugs? Y N

If yes, please list each one:_____

_____

_____

Have you ever taken bisphosphonate drugs (Fosamax, Boniva, etc.

used to treat osteoporosis or multiple myeloma)? Y N

HABITS

Did you or do you have any of the following habits?:

Clenching/Grinding teeth	Y	N	Nursing bottle habits	Y	N
Lip sucking/biting	Y	N	Thumb/Finger sucking	Y	N
Mouth breather	Y	N	Tongue Thrust	Y	N
Nail biting	Y	N			

Would you like to discuss finances without child present? Y N

MEDICAL HISTORY

Current Physician? _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Abnormal Bleeding	Y	N	Handicaps/Disabilities	Y	N
Artificial Bones/Joints	Y	N	Hearing impairment	Y	N
Arthritis	Y	N	Heart Problems	Y	N
Asthma	Y	N	Hepatitis	Y	N
Blood Pressure problems	Y	N	HIV+/AIDS	Y	N
Cancer/Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Chicken Pox	Y	N	Mitral Valve Prolapse	Y	N
Convulsions/Epilepsy	Y	N	Psychiatric Treatment	Y	N
Diabetes	Y	N	Rheumatic/Scarlet fever	Y	N
Difficulty Breathing	Y	N	Shingles	Y	N
Fainting Spells	Y	N	Sinus Problems	Y	N
Fever Blisters/Cold Sores	Y	N	Tuberculosis	Y	N

For Women : Are you taking birth control pills? Y N

Are you pregnant? Y N

If yes, Week #: _____

Are you nursing? Y N

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N

Other: _____

_____

Please elaborate on any dental or orthodontic concerns and any additional medical concerns: _____

_____

_____

_____

_____

_____

_____

I hearby state that the information on this form is true and correct to the best of my knowledge and understand that where appropriate, credit bureau reports may be obtained. I agree to allow Dr. Burton to contact my family dentist, physician and other health care professionals as required to permit proper treatment.

Signature (Parent/Guardian if minor): _____ Date: _____

Reviewed by Dr. Burton: _____ Date: _____