BUCHLER
ORTHODONTICS
AMYBUCHLERDMD

Patient Information

Please complete both front and back sides.

Date: _____

Patient's Name _____ Prefers to Be Called _____

Parent's Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Do You Prefer Text or Email Reminders? _____

Name of Family Members in Orthodontic Treatment: _____

Whom May We Thank For Referring You To Our Office? _____

RESPONSIBLE PARTY INFORMATION

Custodial Parent(s) Name(s) _____

Patient lives with (check all that apply) ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Grandparent(s) ❑ Other _____

Father's Full Name _____ Title: ❑ Mr ❑ Dr ❑ Other _____

Occupation _____ Email Address _____

Address (If Different) _____

Home Phone (If Different) ( ) _____-_____ Cell Phone ( ) _____-_____ Work Phone ( ) _____- _____

Mother's Full Name _____ Title: ❑ Mrs ❑ Ms ❑ Dr ❑ Other _____

Occupation _____ Email Address _____

Address (If Different) _____

Home Phone (If Different) ( ) _____-_____ Cell Phone ( ) _____-_____ Work Phone ( ) _____- _____

Who is financially responsible for this account? _____

Who will be responsible for bringing the patient to appointments? _____

PRIMARY INSURED INFORMATION

Name of Insured: _____
Insured's Birthday: _____ SSN: _____
Relationship to Patient: _____
Address of Insured: _____
City: _____ State: _____ Zip: _____
Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Dental Insurance Co. Name: _____
Ins. Address: _____
City: _____ State: _____ Zip: _____
Ins. Group#: _____ Ins. Phone: _____

SECONDARY INSURED INFORMATION

Name of Insured: _____
Insured's Birthday: _____ SSN: _____
Relationship to Patient: _____
Address of Insured: _____
City: _____ State: _____ Zip: _____
Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Dental Insurance Co. Name: _____
Ins. Address: _____
City: _____ State: _____ Zip: _____
Ins. Group#: _____ Ins. Phone: _____

MEDICAL HISTORY

Physician _____

Please Check Yes or No (If Yes, please fill in details)

❑ Yes ❑ No Are you taking any medication? _____

❑ Yes ❑ No Do you have any allergies to medicines, latex or metals? _____

❑ Yes ❑ No Have you ever been involved in a serious accident? _____

❑ Yes ❑ No Do you smoke? If Yes, how much? _____

❑ Yes ❑ No Are you pregnant now? _____

Please Circle Yes or No For Any Of The Medical Conditions Below That You Have Had Or Currently Have.

Yes	No	Abnormal Bleeding	Yes	No	Diabetes	Yes	No	Hepatitis/Liver Problems	Yes	No	Prolonged Bleeding
Yes	No	Allergies (Seasonal)	Yes	No	Epilepsy	Yes	No	Herpes	Yes	No	Psychiatric/Learning Problems
Yes	No	Anemia	Yes	No	Fainting Spells	Yes	No	High/Low Blood Pressure	Yes	No	Radiation/Chemotherapy
Yes	No	Arthritis	Yes	No	Gastrointestinal Disorders	Yes	No	HIV / Aids	Yes	No	Sinus/Breathing Problems
Yes	No	Asthma	Yes	No	Heart Problems/Murmur	Yes	No	Kidney Problems	Yes	No	Tonsils Removed
Yes	No	Depression	Yes	No	Hemophilia	Yes	No	Osteoporosis	Yes	No	Tumor or Cancer

Are There Any Medical Conditions We Have Not Discussed That You Feel We Should Be Aware Of? _____

_____

_____

DENTAL HISTORY

What Concerns You Most About Your Teeth? _____

General Dentist _____ Date Of Last Visit _____

Other Dentists/Specialists now being seen_____ Reason _____

❑ Yes ❑ No Are you aware that some appointments will be during work hours? _____

❑ Yes ❑ No Have you ever been evaluated for ortho treatment? If yes, with who and when? _____

❑ Yes ❑ No Have you ever had problems with any previous dental work? _____

❑ Yes ❑ No Have you ever been diagnosed with gum disease? _____

❑ Yes ❑ No Do you have any type of thumb or tongue habit? _____

❑ Yes ❑ No Are you a mouth breather? _____

❑ Yes ❑ No Do you now or have you ever experienced pain, clicking or popping noises in your jaw joint? _____

❑ Yes ❑ No Has your jaw joint ever locked or felt like it was sticking? _____

❑ Yes ❑ No Have you ever had an injury to your mouth, teeth or chin? _____

❑ Yes ❑ No Do you grind or clench your teeth? _____

AUTHORIZATIONS

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company. I authorize payment of dental benefits directly to this office. I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify the doctor of any change in my health history. In addition I authorize Dr. Amy Buchler to perform a complete orthodontic evaluation.

Patient or Legal Guardian Signature:_____Date:_____

Dr. Signature: _____ Date: _____