



JEFFREY A. BUNKERS
DDS • MS • INC
ORTHODONTICS EXCLUSIVELY

To Our Office

1 Tell Us About Yourself

Name first & last _____

I preferred to be called _____

M F Birth date ____/____/____ Age _____

Home Address _____

Employer _____

Occupation _____

Home# _____ Cell# _____

Work# _____ Best daytime # _____

Email _____

Marital Status: Single Partnered Divorced
 Married Separated Widowed

Any other family members seen by us? Y N

If yes, their name _____

Who may we thank for referring you? How did you hear of us? _____

2 Spouse Information

His or Her Name _____

Occupation _____

Cell# _____

Work# _____ Ext _____

Best daytime # _____

3 Person Responsible for Account

Name _____ Relation _____

DL# _____ SS# _____

Billing Address _____

Home# _____ Cell# _____

Work# _____ Best daytime # _____

4 Insurance Information

Primary Plan Orthodontic Coverage? Y N

Policy Owner's Name _____

Relation to Patient _____

Policy Owner's SS# or ID# _____

Policy Owner's Birth date _____

Insurance Company _____

Employer _____

Group # _____

For Staff Use: Coordination of Benefits _____

LTM _____ Paid At _____ Amount Used _____

Secondary Plan Orthodontic Coverage? Y N

Policy Owner's Name _____

Relation to Patient _____

Policy Owner's SS# or ID# _____

Policy Owner's Birth date _____

Insurance Company _____

Employer _____

Group # _____

For Staff Use: Coordination of Benefits _____

LTM _____ Paid At _____ Amount Used _____

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Medical History

Please describe your current

physical health: Good Fair Poor

Are you currently under the care

of a physician? Y N

If yes, please describe? _____

Your Physician: _____ Last Visit _____

List any drugs you are currently taking:

For Women: Are you pregnant? Y N

Do you smoke or use tobacco in any form? Y N

Have you experienced any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Cancer/Chemo/Radiation | <input type="checkbox"/> Disabilities/Handicaps |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Facial Injury |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Growth Problems |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Measles/Mumps/Chicken Pox | <input type="checkbox"/> Rheumatic/Scarlet Fever |
| <input type="checkbox"/> Surgery/Hospitalization | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Breathing Problems |

Please describe any other serious medical problems: _____

Allergic to any of the following:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Dental Anesthetics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Metal/Nickel |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex/Plastic |

Please list any other drug/material allergies: _____

Thank you for completing this form.

I affirm that the information I have given is correct to the best of my knowledge. I also understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in medical or dental status. I authorize Dr. Bunkers and staff to perform any necessary dental services or inquiries that may be needed for diagnosis.

Signature _____

Date _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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Dental History

Your Dentist _____ Last visit _____

What are the main concerns that you would like braces to accomplish?

Have you ever been evaluated or had

orthodontic treatment before? Y N

If yes, then by whom? _____ Date _____

Any injuries to the teeth or mouth? Y N

If yes, please describe? _____

Any problems associated with previous dental work? Y N

If yes, please describe? _____

Have you been informed of any missing

or extra permanent teeth? Y N

Do you brush daily? Y N Floss? Y N

Have you experienced any of the following?

Mouth Breathing Y N

Speech Problems Y N

Clenching/Grinding teeth Y N

Pain in jaw joints/muscles Y N R L

Clicking/popping jaw joint Y N R L

ringing in ears Y N R L

Describe any pain in muscles or joints of head and neck _____

Describe methods you use to relieve pain _____

This space reserved for staff use.

Any additional insurance coverage

Family fee information

Appointments needed or scheduled

Misc
