JEFFREY A. BUNKERS
DDS • MS • INC
ORTHODONTICS EXCLUSIVELY

To Our Office

1 Tell Us About Your Child

Name first & last___________________________Nickname___________

☐ M ☐ F Birth date____/_____/______ Age __________

School _______________________________ Grade ________

Child's Home Address ______________________________________

____

Child's Home Phone ____

Email

2 Who is With Your Child Today?

Name _______________________________ Relation ________________

Do you have legal custody of this child? ☐ Y ☐ N

Whom may we thank for referring you?

____

3 Parent's Information

Marital Status: ☐ Single ☐ Partnered ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Mother ☐ Step Mother ☐ Guardian

Name____

Occupation____

Home Address ☐ Same as child

____

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Home#_______________________ Cell#________________________

Work#________________Ext_____ Best daytime #_______________

Email ____

Father ☐ Step Father ☐ Guardian

Name____

Occupation____

Home Address ☐ Same as child

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____

Home#_______________________ Cell#________________________

Work#_______________Ext_____ Best daytime # _________________

Email ____

4 Person Responsible for Account

Name_______________________________ Relation________________

DL#________________________SS#___________________________

Billing Address ☐ Same as child

____

____

Home#_______________________ Cell#_______________________

Work#________________________ Best daytime # ______________

Who is responsible for making appointments?

Name____

Daytime# ___________________ Evening#_____________________

5 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*_____________

CONTINUED ON BACK

6 Medical History

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Child's Physician: ______________________ Last Visit ______________

Is the child currently under the care of a physician? ☐ Y ☐ N

If yes, please describe? ______________________________________

Has puberty begun? Age _____ ___ ☐ Y ☐ N

Girls - menstruation begun? Age ________ ☐ Y ☐ N

Boys - voice changed? Age ________ ☐ Y ☐ N

List any drugs you child is currently talking:

____

Has your child experienced any of the following:

☐ Asthma	☐ Bleeding Problems
☐ Bone Fracture	☐ Convulsions/Epilepsy
☐ Cancer	☐ Disabilities/Handicaps
☐ Diabetes	☐ Emotional Problems
☐ Eye Problems	☐ Facial Injury
☐ Fainting	☐ Growth Problems
☐ Hearing Problems	☐ Heart Problems
☐ Kidney/Liver Disease	☐ Hepatitis
☐ Measles/Mumps/Chicken Pox	☐ Rheumatic/Scarlet Fever
☐ Surgery/Hospitalization	☐ Tuberculosis (TB)

Please describe any medical problems: ___________________________

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Allergic to any of the following:

☐ Aspirin	☐ Dental Anesthetics
☐ Penicillin	☐ Erythromycin
☐ Tetracycline	☐ Metal/Nickel
☐ Codeine	☐ 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.

7 Dental History

Child's Dentist ____

Last visit ____

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

____

____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Y ☐ N

If yes, then by whom? ________________________ Date __________

Any injuries to the teeth? ☐ Y ☐ N

If yes, please describe? ____________________________________

Have you been informed of any missing or extra permanent teeth? ☐ Y ☐ N

Has anyone in your family previously had orthodontic treatment? ☐ Y ☐ N

Does your child brush daily? ☐ Y ☐ N

Floss teeth daily? ☐ Y ☐ N

Has your child experienced any of the following?

Clenching/Grinding teeth ☐ Y ☐ N

Lip Sucking/Biting ☐ Y ☐ N

Mouth Breathing ☐ Y ☐ N

Speech Problems ☐ Y ☐ N

Thumb/Finger Sucking ☐ Y ☐ N

Tongue Thrust ☐ Y ☐ N

This space reserved for staff use.

Any additional insurance coverage

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Sibling fee information

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____

Appointments needed or scheduled

____

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____

____

Misc

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