David M. Bunkall, D.D.S., M.S., P.A.

o r t h o d o n t i c s

Orthodontic Registration and Acquaintance Card

Name: ___________________________________ **SS#:** ______ - _____ - _______ **Date of Birth:** ____/____/______ **Gender:** _____

Address: ____ **City:** ____________________ **State:** _____ **Zip:** _______________

Phone #: ____________________ **Dentist:** ________________________________ **Physician:** ________________________________

Whom may we thank for referring you to our practice? ____

What is the primary concern about your teeth? ____

MEDICAL HISTORY *(Circle all that apply)*

Heart Trouble
Rheumatic Fever
Heart Murmur
Blood Pressure Problem
Asthma
Tuberculosis
Emphysema
Ulcers
Stomach or Bowel Trouble
Hepatitis
Liver Disease
Kidney or Bladder Disease
Sexually-Transmitted Disease
Bleeding Problems
Sickle-Cell Anemia
Stroke
Seizures / Epilepsy
Paralysis
Arthritis
Joint Swelling
Skin Disease
HIV+
AIDS
Cancer
Psychological / Emotional Problems
Allergies
Thyroid or other Gland Problems
Diabetes
Hearing or Taste Problems
Glaucoma
MRSA ***(Methicillin resistant staphylococcus aureus)***

DENTAL HISTORY *(Circle all that apply)*

Injuries to Teeth and/or Face (Describe)____
Finger/Thumb Sucking or Pencil Biting
Lip or Nail Biting
Mouth Breathing
Jaw Joint (TMJ) Clicking/Locking/Pain
Grinding or Clenching Teeth
Fillings/Caps/Crowns/Veneers (Describe)____
Root Canals
Teeth Pulled (Describe)____
Other Oral or Facial Surgery (Describe)____
Periodontal Treatment (Describe)____
Oral Biopsy (Describe)____
Tooth Bleaching
Fluoride or Peridex Rinses
Cold Sores or Canker Sores

Please answer all of the questions that apply:

Play a musical instrument? (what & hours per week)__________________________________
Do you regularly cradle a telephone headset between chin & shoulder? Yes____ **No** ____
Use tobacco in any form? Yes ____ **No** ____ (Describe)_______________________________
Drink more than 3 servings of alcohol per day? Yes ____ **No** ____
Take medications regularly? (Describe)____
Allergic to medications? (Describe)____
Have you ever had radiation treatment or chemotherapy? Yes ____ **No** ____
Ever hospitalized over-night? (Describe)____
Date of last visit to dentist, and for what purpose? ___________________________________
____
Date of last visit to physician, and for what purpose? _________________________________
____
(women) Are you pregnant? Yes ____ **No** ____

Is there anything else I should know about your medical, dental, or psychological history? ______________________________

Vocation: _______________________________________ **Hobbies:** ____

Employed by: ____ **How long?** ____________________ **Work Phone:** __________________

Spouse's Name: ________________________________ **Employed by:** __________________________________ **Work Phone:** __________________

Person(s) Responsible for this Account: ____ **SS#:** _______ - _____ - _________

Orthodontic Insurance Company: __________________________________ **Policy #:** _______________________ **Group #:** ______________________

Person to Notify in Case of Emergency: ______________________________________ **Relationship:** ____________ **Phone #:** __________________

To the best of my knowledge the above information is complete and correct. I hereby give permission to Dr. David M. Bunkall to examine me and secure orthodontic diagnostic records. I also give Dr. Bunkall permission to verify my insurance coverage and, at his discretion, to run a credit check.

Signature ____ **Date** ________________________________