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

Child's Name: ___________________________________ **Name child prefers to be called:** ___________________________________

SS#: ______ - _____ - _______ **Date of Birth:** ____/____/____ **Age:** _____ **Gender:** _____ **Home Phone:** ____________________

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

Dentist: ____ **Physician:** ____

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

What is the primary concern about your child's teeth? ____

MEDICAL HISTORY *(Circle all that apply)*

Heart Trouble
Rheumatic Fever
Heart Murmur
Blood Pressure Problem
Asthma
Tuberculosis
Diabetes
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
Other (please list) _____________________
____

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)____
Oral or Facial Surgery (Describe)____
Gum Treatment (Describe)____
Orthodontic Treatment (Describe)____
Sealants
Fluoride Treatments
Cold Sores or Canker Sores

Please answer all of the questions that apply:

Medications taken regularly? (Describe) ____
Allergic to medications? (Describe)____
Use tobacco in any form? Yes ____ No ____ (Describe)________________________________
Use illegal drugs? Yes ____ No ____
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? _________________________________
____
Are immunizations up-to-date? Yes ____ No ____

Is there anything else I should know about the medical, dental, or psychological history? ____

Father's Name: ________________________________ **Employed by:** ____________________________________ **How long:** _______________

Work Phone: _____________________________________ **Home Phone:** __________________________________

Mother's Name: _______________________________ **Employed by:** ____________________________________ **How long:** _______________

Work Phone: _____________________________________ **Home 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 my child 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 ____ **Relationship to Child:** ___________________ **Date** ___________________