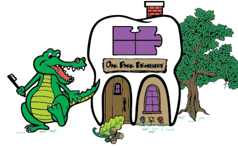

Matthew J. Bruno D.D.S., M.S. **Jelson Yalung D.D.S., M.S.**

Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY - Child (Confidential)

Date ______________________________

PATIENT INFORMATION

Patient's Name ____ Prefers to be called _____________________________
Birthdate _____/_____/_____ Age __________ Sex __________
Address _________________________________ City ______________________ State ______ Zip ___________________
Home Phone ( ) ________________ Cell Phone ( ) ________________ E-mail Address _______________________
If student, Name of School ____________________________________City ____________________ State _____________
Sibling(s) Treated in this Office ____
Person to Contact in Case of Emergency______________________________________ Phone ( ) __________________
Parents' Marital Status: Single Married Widowed Divorced Separated
Parent #1 Name ____________________________ Home Phone ( ) ____________ Cell Phone ( ) ____________
Address _________________________________ City _______________________ State ______ Zip _________________
Occupation ____ Work Phone ( )_____________
Parent #2 Name ___________________________ Home Phone ( ) _____________ Cell Phone ( ) ____________
Address _________________________________ City _______________________ State ______ Zip _________________
Occupation ____ Work Phone ( )_____________
Whom May We Thank For Referring You to Our Office? ____

PERSON RESPONSIBLE FOR THIS ACCOUNT

First Name ___________________________________ MI ______ Last Name _______________________________________
Address _________________________________ City _______________________ State ______ Zip __________________
Occupation ____
Home Phone ( ) ___________________________________ Cell Phone ( ) ____________________________________
Employer ____ Social Security # __________________________
Business Address ________________________________ City _______________________ State _____ Zip ____________
Relationship to Patient (Please circle) Parent Step Parent Legal Guardian Other
Person Responsible for Making Appointments: Name _____________________________ Phone ( ) _______________

ORTHODONTIC INSURANCE INFORMATION

Name of Insurance Company ____Policy # _______________
Address _________________________________ City _______________________ State ______ Zip __________________
Policy Owner ___________________________ Social Security # / ID #________________ Birthdate _____/_____/_____
Subscriber Relationship to Patient_________________________________ Insurance Co. Phone ( )_________________

PERSONAL INFORMATION

What is the main problem as you see it? ____
Has anyone in the family received orthodontic treatment? _______ Who? _____________________________________
How would you describe your child's temperament? ____
Is your child sensitive about the appearance of his/her teeth? ____
How does your child feel about wearing braces? ____
Patient's hobbies or interests ____

MEDICAL

Physician's Name ____________________ Approximate date of last medical examination ______________

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N	Y/N	Y/N	Y/N
Y/N ever been hospitalized	Y/N tonsils removed	Y/N prolonged bleeding	Y/N mouth breathing
Y/N taking medication	Y/N adenoids removed	Y/N diabetes	Y/N snores when sleeping
Y/N allergic to medication	Y/N rheumatic fever	Y/N epilepsy	Y/N sounds "stuffy"
Y/N asthma	Y/N heart disease	Y/N hormone therapy	Y/N frequent sore throats
Y/N other allergies	Y/N heart murmur	Y/N emotional problem	Y/N abnormal growth problems
Y/N hepatitis	Y/N anemia	Y/N arthritis	

Updated

PLEASE EXPLAIN: ____________________

____

____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

____

____

____

GENETIC

	YES	NO
Is the patient adopted?	Y	N
If so, does the patient know this?	Y	N
Has any member of the family had:		
A similar orthodontic condition?	Y	N
A similar facial appearance?	Y	N
A history of early or late puberty changes?	Y	N

PLEASE EXPLAIN:

____

____

____

DENTAL

Dentist's Name ____________________ Approximate date of last dental examination ______________

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N	Y/N	Y/N
Y/N apprehensive about dental care	Y/N speech therapy	Y/N jaw joint pain
Y/N discomfort from teeth	Y/N injury involving teeth	Y/N jaw "tires" at mealtime
Y/N discomfort from gums	Y/N injury to either jaw	Y/N jaw catches when opening
Y/N previous orthodontic therapy	Y/N frequent clenching of teeth	Y/N jaw locks in closed position
Y/N frequent canker sores	Y/N wake up with sore teeth	Y/N facial pain
Y/N previous thumb/finger sucking	Y/N wake up with sore jaw	Y/N frequent headaches
Y/N thumb/finger presently active	Y/N jaw joint sounds	Y/N neck or shoulder pain

PLEASE EXPLAIN: ____________________

____

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Signature of Parent or Guardian ______________________________ Date ______________