WELCOME TO BRACE BUSTERS

PATIENT INFORMATION

Date _____ Patient's Full Name _____ Nickname _____

Birthdate _____ Age _____ Sex _____

Cell Phone _____ Home Phone _____

Email Address _____

Home Address _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Mother ☐ Father

Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Cell Phone _____

Email Address _____ Employer _____

Home Address (If different than above) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Spouse's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Cell Phone _____

Email Address _____ Employer _____

Home Address (If different than above) _____

INSURANCE INFORMATION

Insured's Name _____ Date of Birth _____ Social Security # _____

Employer Name _____ Insurance Company _____

Group Number _____ Policy Number _____ Member ID _____

Do you participate in a Flex Spending Account? ☐ Yes ☐ No

Secondary Coverage? If yes, please continue. ☐ Yes ☐ No

Insured's Name _____ Date of Birth _____ Social Security # _____

Employer Name _____ Insurance Company _____

Group Number _____ Policy Number _____ Member ID _____

NE Philadelphia
211 Geiger Rd.
Philadelphia, PA 19115

Roxborough
6801 Ridge Ave.
Philadelphia, PA 19128

South Philly
330 West Oregon Ave.
Philadelphia, PA 19148

Dresher
1650 Limekiln Pike
Dresher, PA 19025

MEDICAL HEALTH INFORMATION

Patient's Physician: _____ Physician's Address: _____

Does the patient have a history with any of the following (check those that apply):

- ☐ Diabetes
- ☐ Cancer/Radiation/Chemotherapy
- ☐ AIDS/HIV Positive
- ☐ Hepatitis
- ☐ History of eating disorder (anorexia/bulemia)
- ☐ Excessive Bleeding
- ☐ Learning disabilities
- ☐ Seizures/Epilepsy/Fainting Spells
- ☐ Latex or Nickel allergy/sensitivity

- Does the patient have any allergies to other medications, foods, or over-the-counter substances?
  If yes, please explain: _____
- Is the patient taking any medications currently?
  If yes, please list: _____
- Has the patient taken, now or in the past, bisphosphonates (such as Fosamax, Boniva, Didronel, Aredia, Actonel, Skelid, Zometa)?
  If yes, which drug: _____
- Are there any other medical conditions, currently or in the past, that have not been mentioned but that we should be aware of?
  If yes, please explain: _____

For female patients:

- To help us assess your daughter's growth, has she started menstruating? ☐ Yes ☐ No
  If so, at what age? _____
- Is the patient pregnant? ☐ Yes ☐ No

DENTAL HEALTH INFORMATION

- Have you ever had a previous orthodontic consultation or orthodontic treatment?
  If yes, please explain: _____
- Please list any family members who have received orthodontic care in our office: _____
- Who is your general/pediatric dentist? _____
- Is the patient seen for routine check-ups every 6 months? ☐ Yes ☐ No

Does the patient have any of the following (check those that apply):

- ☐ History of gum disease?
- ☐ Pain in the jaw joint?
- ☐ Thumb/Finger sucking habit?
- ☐ Cavities that currently require dental work?

I have read and understand all of the above questions.
I will not hold Brace Busters or any member of its staff responsible for any errors or omissions that I have made in completing this form. If there are any changes to the information I have presented on this date, I will inform Brace Busters.

_____
Signed (Parent or Guardian if patient is a minor)

_____
Date