



Bulleigh Orthodontics

22048 W. 66th St.
Shawnee, KS 66226
(913) 962-7223

8600 W. 95th St. Suite 202
Overland Park, KS 66212
(913) 381-1122

Today's Date: _____

About Yourself

Name: _____
 First MI Last

I Prefer to be Called: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____

Work Phone: () _____ Ext: _____

Birthday: _____ Gender: _____

Marital Status: _____ S.S. #: _____

Cell Phone: _____

Employer/Insurance Information

Employer Name: _____

Employer Mailing Address: _____

 City State Zip

Orthodontic Coverage? Yes No

Insurance Company Name: _____

Insurance Mailing Address: _____

 City State Zip

Insurance Phone: () _____ Ext: _____

Group #: _____ Local or Union #: _____

Spouse Information

Name: _____
 First MI Last

Work Phone: () _____ Ext: _____

Birthday: _____ Gender: _____

S.S. #: _____

Cell Phone: _____

Employer/Insurance Information

Employer Name: _____

Employer Mailing Address: _____

 City State Zip

Orthodontic Coverage? Yes No

Insurance Company Name: _____

Insurance Mailing Address: _____

 City State Zip

Insurance Phone: () _____ Ext: _____

Group #: _____ Local or Union #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____

Relation: _____

Work Phone Number: () _____

Home Phone Number: () _____

Person Responsible for Account?

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____

Work Phone: () _____ Ext: _____

Relation: _____

S.S. #: _____

Whom may we thank for referring you? _____

Dentist's name: _____

Date of last dental visit: _____

List other family members seen by us: _____

Physician's name: _____

Physician's phone number: () _____

Date of last visit with physician: _____

E-mail: _____

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? _____

If yes, please explain: _____

Are you taking any prescription / OTC drugs? _____

Please list: _____

For Women: Are you taking birth control pills? _____

Are you pregnant / nursing? _____ Week # of Pregnancy: _____

Have you ever had any of the following diseases or medical problems?

Y N Anemia/Radiation Treatment	Y N Heart Surgery/Pacemaker
Y N Artificial Bones / Joints	Y N Hemophilia / Abnormal Bleeding
Y N Artificial Valves	Y N Hepatitis
Y N Asthma / Arthritis	Y N High / Low Blood Pressure
Y N Blood Transfusion	Y N HIV+ / AIDS
Y N Cancer / Chemotherapy	Y N Hospitalized for Any Reason
Y N Congenital Heart Defect	Y N Kidney Problems
Y N Diabetes / Tuberculosis (TB)	Y N Mitral Valve Prolapse
Y N Difficulty Breathing	Y N Psychiatric Problems
Y N Drug / Alcohol Abuse	Y N Rheumatic / Scarlet Fever
Y N Emphysema / Glaucoma	Y N Severe / Frequent Headaches
Y N Epilepsy / Seizures / Fainting	Y N Shingles
Y N Fever Blister / Herpes	Y N Sinus Problems
Y N Heart Attack / Stroke	Y N Ulcers / Colitis
Y N Heart Murmur	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Dental Anesthetics	Y N Penicillin
Y N Any Metal / Plastic	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other

Please list any other drugs that you are allergic to: _____

DENTAL HISTORY

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

Have you ever been evaluated for orthodontic treatment? _____

Have you ever had a serious / difficult problem associated with any previous dental work? _____

Do you now or have you ever experienced pain/discomfort in you jaw joint (TMJ / TMD)? _____

Your current dental health is:
 Good Fair Poor

Do you like your smile? _____

Do your gums ever bleed? _____

Have you ever had an injury to your:
 Mouth Teeth Chin

Do you have any speech problems? _____

Do you generally breathe through your mouth?
Awake? Y N Asleep? Y N

Any missing or extra permanent teeth? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Thank you for filling out this form completely.

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature _____

Date _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.