



Tyson F. Buck, DMD, MS  
2650 Washburn Way, Suite 210  
Klamath Falls, OR 97603  
541.882.4461

**PATIENT INFORMATION**

DATE: \_\_\_\_\_

Name: \_\_\_\_\_

                    Last                                    First                                    Middle                                    Nickname

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

Address: \_\_\_\_\_

                                    Street                                    City                                    State                                    Zip

Home Phone: \_\_\_\_\_ Alt/ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Dentist: \_\_\_\_\_ Physician: \_\_\_\_\_ Father Height: \_\_\_\_\_ Mother Height: \_\_\_\_\_

Other family members seen in our office: \_\_\_\_\_

Who can we thank for referring you to our office: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Number of Years at Current Address: \_\_\_\_\_ Number of Years at Current Address: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell): \_\_\_\_\_ Email: \_\_\_\_\_ (Cell): \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ # Years: \_\_\_\_\_ Occupation: \_\_\_\_\_ # Years: \_\_\_\_\_

Single Married Separated Divorced (circle one) Single Married Separated Divorced (circle one)

Spouses Name: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Employer: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ # Years: \_\_\_\_\_ Occupation: \_\_\_\_\_ # Years: \_\_\_\_\_

Patient Lives With (circle one): Mother Father Both Other \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name of nearest relative not living with you & relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Alt/Cell Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Insured's Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Do you have Dual Coverage? Y / N

2<sup>nd</sup> Insured's Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

**MEDICAL & DENTAL HISTORY**

How is the present health of the patient? \_\_\_\_\_

How is the present growth & development of the patient? \_\_\_\_\_

Has the patient been under a physician’s care during the last 2 years? Y / N      Is the patient taking any medication? Y / N

If so, what medication? \_\_\_\_\_

List any allergies: \_\_\_\_\_

(Females only) Is the patient pregnant? Y / N      Due date? \_\_\_\_\_

Has the patient ever had any of the following?

- |       |                                     |            |       |   |
|-------|-------------------------------------|------------|-------|---|
| Y / N | Abnormal bleeding/ Hemophilia       |            | Y / N | High Blood Pressure/Low Blood Pressure  |
| Y / N | Adenoids/ Tonsils removed           | Age? _____ | Y / N | HIV/AIDS                                |
| Y / N | Anemia                              |            | Y / N | Hospitalized                            |
| Y / N | Arthritis                           |            | Y / N | Immune Disorders                        |
| Y / N | Asthma/ Hay Fever                   |            | Y / N | Kidney Disease                          |
| Y / N | Bone Disorders                      |            | Y / N | Lung Disease                            |
| Y / N | Breathing Problems                  |            | Y / N | Major Injuries                          |
| Y / N | Cancer or Tumor                     |            | Y / N | Neck Pain                               |
| Y / N | Chest Pain                          |            | Y / N | Nervous Disorders                       |
| Y / N | Diabetes/Low Sugar                  |            | Y / N | Other serious illness                   |
| Y / N | Endocrine Disease                   |            | Y / N | Pneumonia                               |
| Y / N | Eating Disorder                     |            | Y / N | Radiation/Chemotherapy                  |
| Y / N | Epilepsy                            |            | Y / N | Rheumatic Fever                         |
| Y / N | Fainting/Dizziness                  |            | Y / N | Sinus Problems                          |
| Y / N | Gastrointestinal Disorders          |            | Y / N | Skin Disorder                           |
| Y / N | Glaucoma                            |            | Y / N | Thyroid Disorders                       |
| Y / N | Headaches                           |            | Y / N | Tuberculosis                            |
| Y / N | Heart Defects/Disease/Murmur        |            | Y / N | TMD / Jaw problems                      |
| Y / N | Hepatitis/Liver Disease             |            | Y / N | Vision, Hearing, Speech Problems        |
| Y / N | Herpes                              |            |       |   |
| Y / N | Face, Head, Neck, or Teeth Injuries |            | Y / N | Early loss of any baby teeth            |
| Y / N | Difficulty chewing                  |            | Y / N | Usually breathe through mouth           |
| Y / N | Mouth ulcers/ sore gums             |            | Y / N | Missing or extra permanent teeth        |
| Y / N | Teeth sensitive to hot and/ or cold |            | Y / N | Play a wind instrument      Type? _____ |
| Y / N | Suck thumb or have other habits     |            | Y / N | Endodontic work                         |
| Y / N | Grind teeth                         |            | Y / N | Periodontal work                        |
| Y / N | Bite fingernails                    |            | Y / N | Permanent teeth removed                 |

Please explain any “YES” answers to the above questions? \_\_\_\_\_

What are the names and ages of other children living at home? \_\_\_\_\_

Have you had any previous orthodontic treatment in the family? \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_ How often does the patient brush their teeth? \_\_\_\_\_ floss? \_\_\_\_\_

What concerns you most about the patient’s teeth or facial appearance? \_\_\_\_\_

*I attest to the accuracy of this information and acknowledge that it is my responsibility to notify this office of any medical/dental or contact changes; I authorize release of any information to a third party for insurance claims, education, and/or treatment. I consent to the examination and understand that a credit bureau check may be obtained where necessary.*

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_