Busciglio Smiles
Orthodontics & Pediatric Dentistry

Board Certified Orthodontics & Pediatric Dentistry

# Welcome to Busciglio Smiles

## PATIENT

EMAIL: _____

PATIENT'S NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH _____ AGE _____ SEX M F PHONE # _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

EMPLOYER _____ OCCUPATION _____

## INSURANCE

DO YOU HAVE DENTAL INSURANCE? Y N

WHO IS THE PRIMARY INSURANCE CARRIER? PATIENT SPOUSE FATHER MOTHER

DENTAL INS. COMPANY _____

PHONE NUMBER _____ SS # _____

NAME OF SUBSCRIBER _____ BIRTHDAY _____

ADDRESS _____ PHONE _____

EMPLOYER _____

**PLEASE NOTE: YOU'RE RESPONSIBLE TO NOTIFY US OF ANY CHANGES IN YOUR INSURANCE & WILL BE FINANCIALLY RESPONSIBLE FOR ANY PORTION THE INSURANCE DOES NOT COVER**

## REFERRAL

HOW DID YOU HEAR ABOUT US? _____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

## MEDICAL/DENTAL HISTORY

PATIENT'S DENTIST _____

DATE OF LAST CLEANING _____ REFERRED BY DENTIST Y N

## PLEASE ANSWER ALL QUESTIONS

| | Y | N |
|---|---|---|
| HAVE THERE BEEN INJURIES TO THE FACE, MOUTH OR TEETH? | ☐ | ☐ |
| HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? | ☐ | ☐ |
| DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? | ☐ | ☐ |
| HAS THE PATIENT EVER REACTED TO ANY MEDICINE, SUCH AS PENICILLIN, ASPIRIN, LOCAL ANESTHESIA (DENTAL INJECTION)? PLEASE LIST | ☐ | ☐ |
| LIST MUSICAL INSTRUMENTS PLAYED | ☐ | ☐ |
| IS PATIENT ALLERGIC TO ANYTHING (FOOD, POLLEN, ANIMALS, DUST)? IF YES, WHAT? | ☐ | ☐ |

| | Y | N |
|---|---|---|
| HAVE YOU EVER BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? | ☐ | ☐ |
| HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? | ☐ | ☐ |
| HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? | ☐ | ☐ |
| IS THE PATIENT A MOUTH BREATHER? | ☐ | ☐ |
| WHILE AWAKE? | ☐ | ☐ |
| WHILE ASLEEP? | ☐ | ☐ |
| DOES PATIENT BLEED EXCESSIVELY WHEN CUT? | ☐ | ☐ |
| DOES PATIENT HAVE EMOTIONAL, MENTAL OR NERVOUS PROBLEMS? | ☐ | ☐ |
| DOES PATIENT HAVE GOOD PHYSICAL COORDINATION? | ☐ | ☐ |

## HAS PATIENT EVER HAD ANY OF THE FOLLOWING DISEASES OR ILLNESSES?

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Y | N | HEART DISEASE | Y | N | LUNG | Y | N | DIABETES | Y | N | CHICKEN POX |
| Y | N | COUGHING | Y | N | MALIGNANCIES | Y | N | KIDNEY | Y | N | T.B. |
| Y | N | MUMPS | Y | N | WEIGHTLOSS | Y | N | ANEMIA | Y | N | LIVER |
| Y | N | RHEUMATIC FEVER | Y | N | MEASLES | Y | N | FATIGUE | Y | N | HEART MURMER |
| Y | N | EPILEPSY | Y | N | HEMOPHILIA | Y | N | EYE INFECTIONS | Y | N | NIGHT SWEATS |
| Y | N | CONVULSION | Y | N | CEREBRAL PALSY | Y | N | BLEEDING | Y | N | EAR INFECTIONS |
| Y | N | SHORTNESS OF BREATH | Y | N | FREQUENT COLDS | Y | N | CHRONIC SINUS | Y | N | SICKLE CELL |
| Y | N | AIDS/HIV+ | Y | N | HEPATITIS | | | | | | |

## HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES OR ILLNESSES?

| Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|
| Y | N | DIABETES | Y | N | HEART DISEASE | Y | N | T.B. |
| Y | N | CANCER | Y | N | HEMOPHILIA | Y | N | AIDS |

CURRENT MEDICATIONS _____ ALLERGIES _____

HAS YOUR PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR HEALTH? _____ Y N

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION WE SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

_____

_____

I UNDERSTAND THE INFORMATION GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN THE MEDICAL STATUS. I ALSO AUTHORIZE THE STAFF TO PERFORM THE NECESSARY SERVICES NEEDED FOR MYSELF OR MY CHILD.

_____ DATE

_____ PATIENT/PARENT SIGNATURE