

# VINCENT & BULLWINKEL

## ORTHODONTICS

Today's Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M  F

Patient's Preferred Name: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status: Married  Divorced  Separated  Single

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Soc Sec No: \_\_\_\_\_

Name of spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_ Soc Sec No: \_\_\_\_\_

Who will be responsible for the account? \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_

Primary Dentist: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_



Are you in good health? Yes  No  Any history of major illness? Yes  No

Are you presently under the care of a physician for a specific problem? Yes  No

If yes, please explain: \_\_\_\_\_

List any medications taken and why: \_\_\_\_\_

List any drug sensitivities: \_\_\_\_\_

### PLEASE CHECK THE FOLLOWING AS THEY APPLY

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Contact Lenses          | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Allergies or Asthma | <input type="checkbox"/> Speech Problems    |
| <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Head or Facial Injury  | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Heart Trouble           | <input type="checkbox"/> Tonsillitis            | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Endocrine Problems |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Hearing Disorder       | <input type="checkbox"/> Bleeding Problems   | <input type="checkbox"/> Nervous Disorders  |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Adopted            |



Is there a history of serious illness, accident, or operation?      Yes  No

Please List: \_\_\_\_\_

Have there been any injuries to the face/mouth/teeth? \_\_\_\_\_

Have you ever had gum disease? \_\_\_\_\_

Have you been informed of any missing or extra permanent teeth? \_\_\_\_\_

Has an orthodontist been consulted previously? \_\_\_\_\_

Have you had any previous orthodontic treatment? \_\_\_\_\_

Where? \_\_\_\_\_

Has anyone in your family had orthodontic treatment? \_\_\_\_\_

Do you have an unusual amount of stress in your life? \_\_\_\_\_

Reason for seeking orthodontic treatment: \_\_\_\_\_

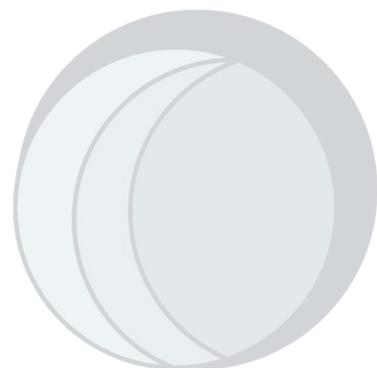
\_\_\_\_\_

Please list additional information which you feel may be helpful: \_\_\_\_\_

\_\_\_\_\_

Do you have dental insurance that covers orthodontic treatment?      Yes  No

If yes, please complete next page



# DENTAL/ORTHODONTIC INSURANCE INFORMATION

To best assist your family in determining orthodontic benefits, the following information is necessary.

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Employer's Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

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

Insurance Company Telephone: \_\_\_\_\_

## IF THE PATIENT HAS ADDITIONAL COVERAGE, PLEASE PROVIDE THAT INFORMATION BELOW

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Employer's Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

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

Insurance Company Telephone: \_\_\_\_\_

I hereby authorize the release of any information relating to this claim.

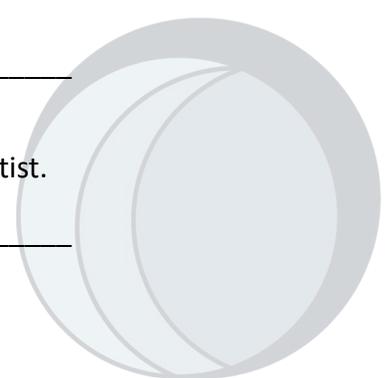
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I hereby authorize the payment of insurance benefits directly to the named orthodontist.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# TEMPOROMANDIBULAR JOINT EVALUATION

1. Please describe your current problem in your own words: \_\_\_\_\_

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|--|-----|----|
| 2. Do you have any difficulty opening your mouth?    | Yes | No |
| 3. Do you hear any noises from the "jaw joint(s)"?   | Yes | No |
| 4. Does your jaw get "stuck," "locked," or "go out"? | Yes | No |
| 5. Do you constantly grind your teeth at night?      | Yes | No |
| 6. Do you constantly clench your teeth together?     | Yes | No |
| 7. Do you have headaches?                            | Yes | No |
| 8. Do you have neck pain?                            | Yes | No |
| 9. Do you have ear aches?                            | Yes | No |
| 10. Do you have muscle spasms in your cheek area?    | Yes | No |

**If you answered yes to any of the above....**

- |  |     |    |
|--|-----|----|
| 1. Is the pain constant?               | Yes | No |
| 2. Is the pain worse in the mornings?  | Yes | No |
| 3. Is the pain worse in the afternoon? | Yes | No |

Please describe the type of pain in your own words: \_\_\_\_\_

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- |  |     |    |
|--|-----|----|
| 11. Do you have any pain when chewing, yawning, or opening wide? | Yes | No |
| 12. Does your bite feel unusual or uncomfortable?                | Yes | No |
| 13. Have you ever had any injury to your jaw, head, or neck?     | Yes | No |

If yes, please explain: \_\_\_\_\_

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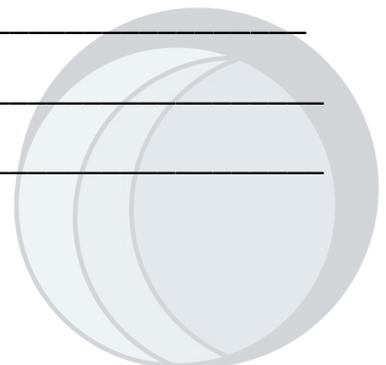
- |   |     |    |
|---|-----|----|
| 14. Do you have arthritis or any bone disorders?          | Yes | No |
| 15. Do you have an unusual amount of stress in your life? | Yes | No |
| 16. Have you ever been treated for TMJ disorder?          | Yes | No |

If yes, please explain when, how, and by whom: \_\_\_\_\_

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*You may refuse to sign this acknowledgement\***

Patient's Name: \_\_\_\_\_

I, \_\_\_\_\_ have received a copy of this office's notice of privacy practices.

Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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



## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other: \_\_\_\_\_