

truForm Usage Instructions

To use this form you must have Acrobat Reader 5 or greater installed.

[Click here](#) to download the current version of Adobe Acrobat Reader.

- Use the tab key to move from form field to form field.
- To enter in text, tab to (or click in) the area you wish to type in and begin typing.
- To check off choices on the form (yes/no type), click in the boxed or underlined area and an “x” or check mark should appear.
- To print out a copy of the form to retain for your records, click on the “Print Form” button toward the bottom of the last page.
- To send the completed form to our office, click “Submit Form” button toward the bottom of the last page.

If you experience difficulty submitting this form, please follow these directions:

1. **Print the form.**
2. **Complete with black pen and bring the form to the office at the time of your appointment.**
3. **If you do not have a printer, you can fill out the form at the office prior to your appointment.**

Please fill out the form as completely as possible. If you have any questions, please contact your doctor.

For your protection:

This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *This form follows HIPAA compliancy rules to ensure the security of your information.*



PUNTILLO

ORTHODONTICS • PC

Orthodontics & Dentofacial Orthopedics for Children & Adults

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

A B C

Patient # _____ Patient Age _____
 Date _____
 Patient's Name _____
 _____ Last First Middle
 Address _____
 _____ Street City State Zip
 Home Phone _____ Birth Date _____ Social Security # _____
 If patient is a minor, give parent or guardian's name _____
 Patient: _____ Responsible Party: _____
 _____ E-mail address _____ E-mail address

RESPONSIBLE PARTY INFORMATION

Name _____
 _____ Last First Middle Marital Status
 Residence _____
 _____ Street City State Zip
 Mailing Address _____
 _____ Street City State Zip
 How long at this address _____ Home Phone _____ Work Phone _____
 Previous address (if less than 3 years) _____
 _____ Street City State Zip
 Social Security # _____ Birth Date _____ Relationship to Patient _____
 Employer _____ Occupation _____ # Years Employed _____
 Spouse's Name _____
 _____ Last First Middle Relationship to Patient
 Marital Status _____
 Spouse's Mailing Address _____
 _____ Street City State Zip
 Spouse's Employer _____ Occupation _____ # Years Employed _____
 Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
 Insurance Company _____ Group # _____ Local # _____
 Insurance Co Address _____
 Insured's Employer _____
 Do you have dual coverage? Yes () No () If yes, please continue: _____
 Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
 Insurance Company _____
 Insurance Co. Address _____
 Insured's Employer _____

EMERGENCY INFORMATION

Name of Nearest Relative not living with you _____
 Complete Address _____
 Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____

I understand that where appropriate credit bureau reports may be obtained.

E.

Medical History

YES

NO

Are you currently under any medical treatment?
If yes, for what? _____

Who is your physician? _____

Are you currently taking any medications?
If yes, list medications. _____

Are you allergic to any medications?
If yes, please list. _____

If you are a woman, are you pregnant?

Have you ever had any of the following? If **yes**, please check.

- () Heart (Surgery, Disease, Attack)
- () Chest pain
- () Congenital Heart Disease
- () Heart Murmur
- () High Blood Pressure
- () Mitral Valve Prolapse
- () Artificial Heart Valve
- () Heart Pacemaker
- () Rheumatic Fever
- () Arthritis / Rheumatism
- () Cortisone Medicine
- () Swollen Ankles
- () Stroke
- () Diet (special / restricted)
- () Artificial joints (hip, knee, etc.)
- () Kidney trouble

- () Ulcers
- () Diabetes
- () Thyroid Problems
- () Glaucoma
- () Contact Lenses
- () Emphysema
- () Chronic Cough
- () Tuberculosis
- () Asthma
- () Hay Fever
- () Latex Sensitivity
- () Allergies or Hives
- () Sinus Trouble
- () Radiation Therapy
- () Chemotherapy
- () Tumors

- () Hepatitis A (infectious) B (serum)
- () Venereal Disease
- () A.I.D.S.
- () H.I.V. Positive
- () Cold Sores / Fever Blisters
- () Blood Transfusion
- () Hemophilia
- () Sickle Cell Disease
- () Bruise Easily
- () Liver Disease
- () Yellow Jaundice
- () Neurological Disorders
- () Epilepsy or Seizures
- () Fainting or Dizzy Spells
- () Nervous / Anxious
- () Psychiatric / Psychological Care

YES

NO

Are there any other health problems not listed?

If yes please describe _____

F.

Dental History

YES

NO

_____	_____	Do you have a general dentist? If yes, print dentist's name. _____
_____	_____	Date of last exam/cleaning. _____
_____	_____	If no, would you like us to refer you to a dentist?
_____	_____	Do you have any dental pain or problems needing attention? If yes, please describe. _____
_____	_____	Do your gums bleed or feel tender?
_____	_____	Have you had gum treatments?
_____	_____	Do you have teeth sensitive to hot / cold / sweets?
_____	_____	Have you had a root canal?
_____	_____	Does food get caught between your teeth?
_____	_____	Are any of your teeth loose?
_____	_____	Have your front teeth separated?
_____	_____	Do you have any missing permanent teeth?
_____	_____	Have you had any permanent teeth extracted?
_____	_____	Do you have a partial plate or complete denture? If yes, does it fit properly? How old is it? _____
_____	_____	Do you have any high dental fillings, crowns or bridges?

G.

Orthodontic History

YES

NO

_____	_____	Have you ever had any orthodontic treatment? If yes, by whom. _____ When? _____
_____	_____	Are you unhappy with your facial appearance and profile?
_____	_____	Are you unhappy with the way your teeth look?
_____	_____	Do you feel your bite is changing?
_____	_____	Have you been bumped, traumatized or fractured any teeth?
_____	_____	Do you have any of the following habits? (circle) Thumb, finger, lip or pacifier sucking, fingernail biting, biting other objects, Other _____
_____	_____	Do you snore?
_____	_____	Is it difficult to breath through your nose?
_____	_____	Do you breath with your mouth constantly open?
_____	_____	Do you have frequent sore throats?
_____	_____	Do you have frequent ear infections or tubes?

Please describe your problem or complaint _____

H.

TMJ (Jaw Joint) History

YES

NO

_____	_____	Do you now or have you ever had a TMJ problem?
_____	_____	If yes, have you ever been treated?
		By whom? Dr. _____
		When? Date: _____
_____	_____	Have your teeth ever been ground down?
_____	_____	Do you have jaw joint or facial pain?
_____	_____	Does it hurt to open wide?
_____	_____	Do you have difficulty opening or jaw locking?
_____	_____	Does your jaw pop or click?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Does your jaw make a grinding noise?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Do your ears ring, ache or feel stuffy?
		If yes circle one. (Right) (Left) (Both)
_____	_____	Do you get dizzy frequently?
_____	_____	Do you clench, grind or grit your teeth?
_____	_____	Do your jaws ache or feel tired?
_____	_____	Do your teeth ache in the morning?
_____	_____	Do you have pain or difficulty swallowing?
_____	_____	Do you have a stiff or painful neck?
_____	_____	Has your jaw or chin ever been bumped or hit?
_____	_____	Have you ever had a head, neck, or whiplash injury?
_____	_____	Do you have frequent headaches?
		If yes, circle the correct descriptions.
		Aching, Shooting, Stabbing, Burning or Electrical
		Intensity: (Severe) (Medium) (Light)
		Worse in: (morning) (afternoon) (evening)

Please describe your problem or complaint _____

I. I represent that all the statements and answers contained herein, are to the best of my knowledge and belief, complete, true and correctly recorded and it is agreed that **Puntillo Orthodontics**, and staff shall not be presumed to have knowledge of any information not so recorded.

Signature: _____ Date: _____

Patient (Parent if Patient is a Minor Child)