



LONGMONT ORTHODONTICS

Let your smile shine!

Patient Information

(confidential)

Date _____

Last Name _____ First Name _____

Date of Birth _____ Age _____

Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____

Whom may we thank for referring you to our office? _____

Who is your dentist? _____ Date of last visit _____

Responsible Party Information

Name of Person Responsible for this Account _____ Relationship _____

Address _____ Home Phone _____

Previous Address (if less than 3 years) _____

Employer _____ Work Phone _____

Social Security # _____ Cell Phone _____

Dental Insurance Information

Name of Insured _____ Relationship _____

DOB _____ Social Security # _____ Date Employed _____

Employer's Name _____ Work Phone _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Company Address _____ City _____

State _____ Zip _____ Phone Number _____

Do you have additional insurance? If yes, please complete the following:

Name of Insured _____ Relationship _____

DOB _____ Social Security # _____ Date Employed _____

Employer's Name _____ Work Phone _____

Insurance Company _____ Group # _____ Policy ID # _____

Insurance Company Address _____ City _____

State _____ Zip _____ Phone Number _____

Thank You! Please turn over and complete the back side of this form.

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

Dental History

Have you ever experienced any of the following?

- Y N Previous orthodontic treatment or evaluation?
 Y N Injuries to the face, mouth, teeth or chin?
 Y N Been informed of any missing or extra teeth?
 Y N Pain/tenderness/popping in the jaw joint?
 Y N Speech problems?

Your current dental health is: Good Fair Poor

Habits

Do/did you have any of the following habits?

- Y N Clenching Teeth
 Y N Grinding Teeth
 Y N Lip Sucking/Biting
 Y N Mouth Breather
 Y N Current Thumb/Finger Sucking Habit
 Y N Past Thumb/Finger Sucking Habit
 Y N Tongue Thrust
 Y N Smoking

Allergies

Are you allergic to any of the following?

- | | |
|------------------------|-------------------------------------------|
| Y N Aspirin | Y N Latex |
| Y N Any Metal/Plastics | Y N Penicillin or any related cillin drug |
| Y N Codeine | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Iodine |
| Y N Erythromycin | Y N Other _____ |
| Y N Any Sulfa Drug | |

Office Notes:

Medical History

Name of Physician _____
 Date of last visit _____
 Are you under the care of a physician? Yes No
 Your physical health is: Good Fair Poor
 For Women: Are you pregnant? Yes No Week # _____
 Are you nursing? Yes No

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

- | | |
|----------------------------------|---------------------------------------------|
| Y N Anemia/Radiation Treatment | Y N Hepatitis |
| Y N Any Hospital Stays | Y N High/Low Blood Pressure |
| Y N Any Operations | Y N HIV+/AIDS |
| Y N Artificial Valves | Y N Kidney/Liver Problems |
| Y N Arthritis | Y N Mitral Valve Prolapse |
| Y N Asthma | Y N Psychiatric Problems |
| Y N Blood Transfusion | Y N Respiratory Problems |
| Y N Cancer/Chemotherapy | Y N Rheumatic/Scarlet Fever |
| Y N Congenital Heart Defect | Y N Severe/Frequent Headaches |
| Y N Convulsions/Epilepsy | Y N Shingles |
| Y N Diabetes | Y N Sinus Problems |
| Y N Drug/Alcohol Abuse | Y N Temporomandibular Joint Disorder |
| Y N Emphysema/Glaucoma | Y N Tuberculosis |
| Y N Fever Blisters/Herpes | Y N Ulcer/Colitis |
| Y N Handicaps/Disabilities | Y N Venereal Disease |
| Y N Heart Attack/Stroke | Y N Orthopedic Total Joint |
| Y N Hearing Impairment | Y N Any complications with Orthopedic Joint |
| Y N Heart Murmur | |
| Y N Heart Surgery/Pacemaker | |
| Y N Hemophilia/Abnormal Bleeding | |

Please list any condition(s) requiring antibiotic pre-medication:

Please list all drugs that the patient is taking:

Additional Comments:

Authorization and Release

I certify that I have answered the above questionnaire accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my medical and dental health. I authorize the office to release any information including the diagnosis and records of any treatment or examination rendered during the period of orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on the patient's behalf. I understand that where appropriate, credit bureau reports may be obtained.

X _____
 Signature of patient (or parent if minor)

_____ Date