LONGMONT ORTHODONTICS

Let your smile shine!

Patient Information

(confidential) Date _____

Patient's Last Name _____ First Name _____ Goes by _____
Date of Birth _____ Age _____ Grade in School _____
Mother's Name _____ Father's Name _____
Address _____ City _____ Zip Code _____
Home Phone _____ Whom may we thank for referring you to our office? _____
Who is your dentist? _____ Date of last visit _____
Please list names and ages of patient's siblings: _____
_____

Responsible Party Information

Name of Person Responsible for this Account _____ Relationship _____
Address _____ Home Phone _____
How long at this address? _____ Previous Address (if less than 3 years) _____
Employer _____ Work Phone _____
Social Security # _____ Cell Phone _____

Secondary Responsible Party (if applicable)

Name _____ Relationship _____
Address _____ Home Phone _____
How long at this address? _____ 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

Has the patient 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?

The patient's current dental health is: Good ☐ Fair ☐ Poor ☐

Habits

Does/did the patient 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

Is the patient allergic to any of the following?

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

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 ☐

Has the patient ever had any of the following diseases or medical problems?

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

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