Longmont
ORTHODONTICS
Let your smile shine!

Patient Information

Date_____

Patient's Last Name_____First Name_____Goes by_____

Date of Birth_____ Age_____Grade in school_____

Mother's name_____Father's name_____

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

Who is your child's dentist?_____Date of last visit_____

Responsible party information

Name of person responsible for this account_____Relationship_____

Address_____City_____Zip Code_____

Phone #_____ E-mail address_____

Do you prefer text or e-mail for appointment reminders?

Dental Insurance Information

Name of Insured_____Relationship_____

Social Security # _____DOB_____

Employer's name_____

Insurance company_____Phone number_____

Insurance address_____

Group #_____Policy ID #_____

Please let us know if you have any additional dental coverage. ☐

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

_____

_____

_____

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

Dental History

Has your child 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 Speech problems
Y N Sensitive or sore teeth

Your child's current dental health is: Good Fair Poor

TMJ

Does your child experience the following?

Y N Pain or tenderness in jaw joint
Y N Popping or clicking in jaw joints
Y N A history of head or neck trauma
Y N Ringing or fullness in ears
Y N Headaches
Y N Migraines

Habits

Does your child have any of the following habits?

Y N Clenching or grinding teeth
Y N Mouth breathing
Y N Snoring
Y N Current thumb/finger sucking habit
Y N Past thumb/finger sucking habit
Y N Tongue thrust
Y N Smoking
Y N Recreational drug use

Allergies

Is your child allergic to any of the following?

Y N Aspirin
Y N Ibuprophen
Y N Any metal/plastics
Y N Dental anesthetics
Y N Latex
Y N Acrylics
Y N Penicillin or any antibiotics
Y N Other _____

Please list any medications your child is taking:

Additional comments:

Medical History

Has your child ever had any of the following medical problems?

Y N Anemia/radiation treatment
Y N Arthritis
Y N Asthma or respiratory problems
Y N Cancer/chemotherapy
Y N Congenital heart defect
Y N Convulsions/epilepsy
Y N Diabetes
Y N Drug/alcohol abuse
Y N Fever blisters/herpes
Y N Glaucoma
Y N Hearing impairment
Y N Heart murmer
Y N Heart surgery
Y N Hemophilia
Y N Hepatitis
Y N High/low blood pressure
Y N HIV+/AIDS
Y N Kidney/liver problems
Y N Psychiatric problems
Y N Rheumatic/scarlet fever
Y N Shingles
Y N Sinus problems or hayfever
Y N Tuberculosis
Y N Ulcers/colitis
Y N Orthopedic joint replacement
Y N Have you taken oral or intravenous bisphoshonates such as Zometa, Aredia, Didronel, Fosamax, Actonel, Boniva, Skelid for bone disorders?
Y N For women: are you pregnant?

Child's current physician:

Date of last visit: