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?

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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: