LONGMONT BRACES

Patient Information

Today's Date ____________________

☐ Male ☐ Female

Name ________________________________
First MI Last

Preferred Name ____________________________

Date of Birth ______________ Age ___________

Medical/Dental History

Primary Dentist ___________________________

Primary Care Physician _____________________

Are you taking any

Prescription medication? ☐ Yes ☐ No

If so, which ones __________________________

Are you currently taking a bisphosphonate for osteoporosis?

☐ Yes ☐ No

List any drug sensitivities ____________________

Please check all that apply:

☐ Asthma ☐ Jaw Joint Pain ☐ Teeth Grinding

☐ Diabetes ☐ Bone Disorders ☐ Heart Condition

☐ Epilepsy ☐ ADD/ADHD ☐ AIDS/HIV

☐ Hepatitis ☐ Other __________________

Have you been informed of any missing/extra teeth? ☐ Yes ☐ No

Has an orthodontist previously been consulted? ☐ Yes ☐ No

Previous orthodontic treatment? ☐ Yes ☐ No

Thumb sucking habit or tongue thrust? ☐ Yes ☐ No

Child Patients Only

School ________________________

Child's hobbies/interests ________________

Is the patient adopted? ☐ Yes ☐ No

Boy: Has his voice changed? ☐ Yes ☐ No

Girl: Has she started menstruation? ☐ Yes ☐ No

If yes, Month/Year ____________

Who does he/she live with?

☐ Both Parents Together ☐ Both Parents Separately ☐ Mother ☐ Father ☐ Other

Responsible Party Information

Name ______________________________

Relationship to Patient ______________________

Employer ___________________________

Occupation __________________________

Work # _____________________________

Email ______________________________

☐ Married ☐ Divorced ☐ Separated
☐ Single ☐ Widowed

Spouse/Other ________________________

Relationship to Patient ______________________

Employer ___________________________

Occupation __________________________

Work # _____________________________

Are there any other children that you would like us to evaluate? ☐ Yes ☐ No

Family Members previously seen:

____

Who may we thank for referring you to our office?

____

Insurance (if not previously give to us)

Primary Dental Insurance

Insurance Company ______________________

Group Number __________________________

Insured's Name _________________________

Relationship to Patient ___________________

Date of Birth ____________ ID/SS# ____________

Secondary Dental Insurance

Insurance Company ______________________

Group Number __________________________

Insured's Name _________________________

Relationship to Patient ___________________

Date of Birth ID/SS#

X ______________________________
Parent/Guardian Signature